



State of Washington



2003 HEDIS REPORT

Quality Assessment, Improvement and Monitoring
Division of Medical Management
Medical Assistance Administration



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Single copies of this report are available through the Division of Medical Management.

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MESSAGE FROM THE DIRECTORS

From Governor Locke on down, Washington State government is committed to improving the access and quality of health care in Washington. Health care ranked as one of 11 key goals in last year's budget deliberations, which were centered for the first time on a new process called "Priorities of Government," or POG. Under POG, administrators of all the state agencies with an interest in health care sat down together to look at all of our health-related activities and to rate their priority for citizens of our state.

But holding health care high in our esteem is just the starting point. It does not replace the hard calculations and measurements that are needed to make sure our health-care system is performing properly and that the care being provided meets the quality standards we have set. You are holding one of the keys to that process – an annual publication that provides information on clinical quality in state-contracted managed care plans. Public reporting of performance ensures accountability and enables replication of successful improvement initiatives. Health plans and others can use the information in this report to evaluate health-care practices and ultimately raise the quality of care for managed-care enrollees.

There is good news in this report. We have clearly made significant progress in some of the performance measures in this report, and steady growth is shown in others. But this report also includes challenges. There are still many opportunities to achieve a higher level of performance, and the State of Washington is committed to working collaboratively and providing support and technical assistance to health plans to attain our common goal of access to high quality health care and preventive services.

We also are moving to find a way to incorporate some of the strategies that have been effective in managed care in the Medicaid fee-for-service program, which provides health care services for the other half of our nearly 1 million clients. Improvement of continuity and coordination of medical care and services must be a priority for all health care, not just managed care.



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EXECUTIVE SUMMARY

This is the sixth annual HEDIS report for Washington State health plans that contract with the Medical Assistance Administration (MAA) and the Health Care Authority (HCA).

Each year health plans report a set of HEDIS measures, selected by MAA and HCA, that are relevant to the populations served. In addition to Childhood Immunization and Prenatal and Postpartum Care, four new measures were required this year: Well Child Care Visits in the First 15 months of Life, Well Child Care Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well Care Visits, and Use of Appropriate Medications for People with Asthma.

This report summarizes health plan performance on these measures in 2002 for the Medicaid and commercial populations. A profile of each health plan is included showing how performance has improved or worsened over a four-year period for measures required since 1999. Statewide median rates for four years are also included.

In the nine measures tracked, variance among health plan rates is narrowing. All health plans improved at least two measures this year and every health plan improved the Varicella Childhood Immunization rate. Over the four-year period from 1999 to 2002, the statewide median rate for Varicella increased significantly (from 26 to 65 percent) and individual health plans achieved up to a fifty percentage point increase. Prenatal care improved significantly in the past four years, with three health plans above the national benchmark of ninety percent this year. Unlike last year, no health plan improved every rate and no single health plan held the highest rank across all measures.

For the past three years, NCQA reported substantial improvements in HEDIS rates among commercial health plans, with data demonstrating how measurement and accountability yield both clinical and economic benefits for health plans. The report, *The State of Health Care Quality 2002*, includes an online Quality Dividend Calculator that shows potential gains for several common health conditions. It is available at www.ncqa.org

By evaluating resources and improvement activities, and using the Quality Dividend Calculator and the information in this report effectively, health plans can achieve those beneficial outcomes over time. The challenge for health plans is to raise the bar of expected performance toward excellence and to mobilize stakeholders toward collaborative initiatives that will improve preventive health care and services in communities across the state.

I. OVERVIEW

Introduction

***"Knowing is not enough; we must apply.
Willing is not enough; we must do."
Goethe***

This vision is applied to health care in a recent article *Escape Fire* written by Donald M. Berwick, MD, MPP, president of the Institute for Healthcare Improvement (IHI). In the forward, vision becomes a value:

"Despite extraordinary knowledge, enormous expenditure and sophisticated technologies, America's health care system has been rated 37th in the world....What is needed...is the courage to acknowledge the shortcomings of our current system and the will to transform it."

Efforts to improve health care quality include large-scale national initiatives, such as the 1998 President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and *Healthy People 2010*. The 2001 Institute of Medicine (IOM) report *Crossing the Quality Chasm: A New Health System for the 21st Century* identifies the reason we fail to translate knowledge into clinical practice as inadequate health care delivery systems. Fundamental to achieving quality improvement is an information system that measures where you are, where you want to be, and how much you change.

One of the available measurement tools in the health care industry is the Health Plan Employer Data and Information Set (HEDIS®).¹ HEDIS is the national standard for managed health care today, and is used by more than ninety percent of health plans in the U.S. to measure quality. HEDIS provides purchasers, health plans and consumers valid and reliable information to measure and compare health plan performance over time.

HEDIS is an important component in the Medical Assistance Administration (MAA) Managed Care Quality Strategy.

This is the sixth annual HEDIS report summarizing the performance of managed health care plans contracting with Washington State to provide health care. The report is widely distributed to help drive quality improvement.

Healthy People 2010, health promotion and disease prevention objectives set by the Department of Health and Human Services for the nation to achieve by 2010, is available at
www.health.gov/healthypeople

¹ HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Who reports?

MAA contracts with managed care plans in Washington to provide health benefits to persons eligible for public assistance. The Health Care Authority (HCA) contracts with most of the same health plans for state employees and the Basic Health (BH) program—the state supplemental program for persons without insurance who have income above the limit established for Medicaid. Both contracts require health plans to collect and report select HEDIS measures for enrolled populations.

Managed care is a prepaid, comprehensive system of health care delivery, including preventive, primary, specialty and ancillary health services.

HEDIS categorizes populations as Medicaid, Medicare, or commercial. Nine health plans are represented in this report, of which six serve both Medicaid and commercial state managed care enrollees. Molina contracts for the Medicaid population only, and PacifiCare for commercial only. The Kaiser Medicaid contract is only for pregnant women and children enrolled in BH. In 2002 Aetna contracted for the commercial population only. This report does not include the Medicare population.

Medicaid is a federal and state jointly administered healthcare program established in 1965 as Title XIX of the U.S. Social Security Act for individuals and families with limited income.

Medicaid. The Medicaid covered population in Washington is around

900,000. About half are children under the age of eighteen. Approximately 50 percent of the Medicaid population in Washington are enrolled in managed care. The Medicaid managed care program in Washington is called Healthy Options.

In this report the Medicaid population includes persons eligible for Medicaid who are enrolled in a health plan, and Medicaid-eligible children of adults enrolled in BH. Children in the State Children's Health Insurance Program (SCHIP) are enrolled in managed care, and most women eligible for Medicaid because of pregnancy. Those receiving Supplemental Security Income (SSI) are eligible for Medicaid but exempt from enrollment in managed care.

Commercial. The commercial population for the health plans represented in this report includes all persons enrolled in a health plan who are not Medicaid or Medicare, including state employees, retirees and dependents, and adults enrolled in BH.

Health Plans and coverage

Health plans contract each year to operate in specific counties. In 2002, the Washington Medicaid managed care program consisted of seven managed care plans operating in 38 of 39 counties.

Most counties had two or three health plans serving the Medicaid population; both King and Pierce counties had five health plans. In twelve counties this year only one health plan contracted for Medicaid. Potential enrollees in counties with no choice between health plans may choose the fee-for-service program instead of enrolling in managed care.

Since 1999, due to mergers and acquisitions, the number of health plans has decreased. Health plan names, the abbreviations used in this report, and the population and counties served are shown in Appendix B.

Report content and changes from 2002

HEDIS is a technically complex process. This report is geared toward a broad audience and provides explanations for readers who may be unfamiliar with performance measure reports, and references and resources for those interested in further detail.

Description. A brief description of each HEDIS measure explains how the rates are calculated. Readers wishing the detailed specifications of measures should refer to *HEDIS 2002 Technical Specifications, Volume 2*, published by NCQA or the NCQA website at www.NCQA.org

Analysis. A summary of the clinical significance for each HEDIS measure explains why it is important and what the rates and variance mean in relation to the health of individual members, the community, and Washington State. The analysis includes health plan overall performance on each measure, high and low achievers, statewide rates, and performance over time for measures that have not changed. Percentages are rounded to the nearest whole number in the text of the report and may differ slightly from actual values.

Tables and graphs. A table for each HEDIS measure shows the rate each health

plan achieved and the number of members in the sample or entire eligible population. Statewide median and average rates are also shown. A multi-year profile for each health plan across all HEDIS measures and certain statewide rates illustrate change (positive and negative). A comparison is not included when there was a material change in the reporting entity, the measure specifications, or how the organization reported the data.

County level Medicaid HEDIS Childhood Immunization rates, based on postal zip codes are provided for 2000, 2001, and 2002 (reflecting services in the prior years). All health plans operate in more than one county and regional performance may uncover local patterns or characteristics important to public health that are not evident at the health plan level (such as pockets of under immunization). Counties with less than thirty in the aggregate denominator are not included in this report.

Format. Changes in the report format this year include:

- Statewide average rates are included to provide comparability with national and other local data.
- Health plan rates for the Medicaid population are accompanied by an arrow to denote rates that are statistically significantly above (↑) or below (↓) the statewide average rate. If the rate change is statistically significant from 1999 to 2002, it is denoted with (↑↑) or (↓↓) in health plan profiles. Statistical differences are calculated using a two-tailed Z test.

- Data tables and charts are integrated in the report instead of in a separate section.
- Improvement strategies are in one section, since many apply across all measures. Approaches that are specific to one measure are identified.
- The Medicaid and commercial populations are in separate sections.

How are HEDIS rates compiled?

HEDIS data—collected, reported, and audited according to rigid technical specifications and standardized methods—ensure reported rates are comparable across health plans.

Rate calculation. Technical specifications for calculating the denominator and numerator for each measure produce a percentage (rate). The rate is the proportion of persons who receive a defined service and meet the eligibility specification, out of the health plan’s total eligible population or random sample of the eligible population. Health plans may choose from two methods to calculate HEDIS rates.

Administrative. The administrative method uses data collected for tracking service utilization and costs through health plan information systems, such as claims, eligibility, enrollment, and encounter data, and calculate a rate using all of the eligible members who satisfy the denominator criteria specified for a measure. The numerator is derived from all members in the denominator who receive the service(s) shown in paid claims.

Encounter and claims data identify the type of service provided and associated diagnosis. Encounter data are not required for payment and are typically less complete than claims data.

Although cost effective, the administrative method lacks clinical depth and may yield lower rates due to errors of omission, data entry, idiosyncratic coding, late submission, or capitated compensation.

Hybrid. In the hybrid method, a random sample of all eligible members in the administrative data is selected, and medical records of members whose claims data do not indicate the service was received are reviewed. These members augment the data when evidence is found that the service was provided, even though the service is not in health plan electronic data.

The hybrid method generally produces a more accurate, higher rate. For example, medical record review can find services provided that are bundled with a single code in a claim. Medical records are better sources of clinical information, but the process is time consuming and expensive, and records can be incomplete or illegible.

A capitated rate is a set amount paid to a provider by the health plan regardless of services provided. Most health plans pay providers on a capitated basis for some services.

Sample size. HEDIS specifications outline a systematic sampling method that assures data integrity. If a measure applies to fewer than 100 members, all eligible members are

included in the sample. When the measure applies to fewer than 30 members, the health plan reports a count of members eligible (denominator) and those who received the service (numerator) but the rates are not publicly reported (shown as “NA” in tables). These numbers are included in statewide aggregate analysis.

A small sample can produce an unusually high or low rate. The size of the sample should always be considered when making comparisons. The sample size is indicated by “N” in the tables.

Confidence Interval. When a sample is collected instead of the entire eligible population, the resulting rate is a statistical estimate. The precision of that estimate is the confidence interval (CI) or margin of error. Small sample sizes produce rates with a greater margin of error. A 95 percent CI (or five percent error margin) for each rate is shown for all measures in this report. The upper (UCI) and lower (LCI) bounds correspond with the ends of the bars in the charts.

Data Submission Tool. With permission from NCQA, state contracted health plans use the Data Submission Tool (DST), an NCQA web-based submission process, to submit auditor-secured HEDIS results to MAA on or before June 30 each year. Using the DST eliminates data reformatting for health plans reporting HEDIS performance to the NCQA publicly reported national database.

Compliance Audit. Health plans self-report HEDIS rates. To ensure the validity of the rates and verify health plan processes, MAA and HCA require health plans to undergo and submit a HEDIS Compliance Audit

report. The audit is a rigorous process, conducted by an independent, NCQA certified auditor. The audit process is outlined in *HEDIS 2002 Compliance Audit, Volume 5*, published by NCQA and described on the NCQA website.

Washington statewide rate

Every year a statewide median aggregate of all health plan rates for the populations represented is calculated to represent the Washington State overall status. Beginning this year we added the statewide average or mean to better compare performance reported as averages by most national, and other state and local entities. Median and mean rates are generally not comparable and the rates can substantially differ, which is important to understand when interpreting the statewide rates.

A median represents the middle point; half are above and half are below that rate. When the number is uneven, the average of the middle two values is the median.

An average or mean is the sum of a list of numbers divided by the total number listed.

The median is retained for childhood immunization and prenatal and postpartum care to maintain surveillance of statewide trends.

How does Washington compare with National benchmarks?

Both the median and the mean can be considered mediocre rates, not benchmarks. Benchmarks are best performance rates

against which performance should be compared, and should be stretch goals—excellent, achievable levels of performance.

To achieve the improvement level necessary to "cross the quality chasm," performance goals at 70 or 80 percent (which means 20 to 30 percent of individuals who should get care do not) are not acceptable. National benchmarks, such as in *Healthy People 2010*, are ambitious goals for all population groups and challenge MAA to stretch toward achieving a level of excellence that has not been reached in the population we serve. Many of the goals in *Healthy People*

2010 are comparable to HEDIS specifications and are noted in this report.

NCQA publishes national commercial HEDIS benchmarks in an annual report, *State of Health Care Quality*, which is available on the NCQA website. The benchmarks are used for NCQA health plan accreditation, and are useful for health plans in comparing commercial rates. Due to the limited number of Medicaid plans submitting audited HEDIS results to NCQA, national Medicaid performance thresholds are not included in this report.

THE MEDICAID POPULATION

II. HEDIS DESCRIPTIONS, RATES, AND ANALYSIS

Required measures

Each year the MAA chooses performance measures most relevant to the Medicaid population. The measures included in this report that were required by state contract in 2003 (representing services provided during the 2002 calendar year) are:

- Childhood Immunizations;
- Prenatal and Postpartum Care;
- Well Child Visits in the First 15 Months of Life;
- Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits; and
- Appropriate Medications for People with Asthma.

CHILDHOOD IMMUNIZATIONS

Weapons of Mass Protection

Why this measure is important

A recent headline referred to childhood immunizations as "weapons of mass protection." The phrase coins a current concept that is catchy, and captures a contemporary truth.

Immunization is a process by which a person is rendered resistant to a specific disease. Maintaining high immunization levels in early childhood is one of the most effective and cost efficient ways to protect against diseases to which children are susceptible at a young age, and the best way to prevent a resurgence of vaccine preventable diseases (VPDs) within communities. The childhood immunization schedule recommended by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) is complex, with up to twenty doses of recommended vaccines for ten diseases by age two.

According to the National Immunization Program (NIP), immunizations in the U.S. have reduced nine childhood diseases over 95 percent. Yet this nation's vaccine system is troubled. Fewer companies produce vaccines and we have experienced vaccine shortages in recent years.

The *Healthy People 2010* goal for full immunization is 90 percent.

Description of the measure

The HEDIS Childhood Immunization measure is a composite that calculates the proportion of children continuously enrolled in the health plan for twelve months prior to their second birthday and who receive the following immunizations by the time period specified and by the child's second birthday:

***4 DTaP (diphtheria-tetanus toxoid-acellular pertussis)**

***3 IPV (injectable poliomyelitis)**

***1 MMR (measles-mumps-rubella)**

***3 HiB (Haemophilus influenza type B meningitis)**

***3 Hep B (Hepatitis B)**

***1 VZV (Varicella or Chicken pox)**

HEDIS also calculates two combination rates. The Combination 1 (Comb 1) rate, which includes all the above immunizations except VZV, is included in this report.

Diphtheria, Tetanus, and Pertussis

(DTaP). DTaP is a combined vaccine that protects against diphtheria, tetanus, and pertussis.

Diphtheria causes obstructed breathing, and can affect the heart and nerves causing paralysis. It was one of the most common causes of childhood death before vaccines and the incidence of diphtheria and tetanus in the U.S. fell more than 99 percent after introduction of the vaccine. Diphtheria kills five to ten people out of every 100 who contract the disease. The last major outbreak in Washington was in Seattle in the 1970s.

Combination vaccines have been used in this country for about sixty years and mean fewer office visits and less trauma for the child.

2002 Childhood Immunization - DTaP

Tetanus (lockjaw) is an acute disease that enters a cut or wound, causing muscle spasms usually involving the jaw and neck initially and later becoming generalized. Three of ten people who get tetanus die. Tetanus Toxoid is a highly effective vaccine and tetanus is rarely reported in the U.S. today.

In Austin, Texas, the third infant this year died from whooping cough. Texas has one of the lowest rates of childhood immunization in the nation and cases have increased from one pertussis case in 2000 to 111 in 2002.

Pertussis (whooping cough) starts with cold symptoms and is often spread by older children or adults who do not produce the characteristic "whoop" that younger children get. It causes severe coughing and can produce chronic lung problems, seizures, and brain damage. Pertussis was virtually eradicated for many years, but is endemic in the U.S. today and continues to cause serious illness and death, particularly among infants under six months of age. Low immunization and waning immunity in adolescents and adults increase the chance that infants will get pertussis. The vaccine is about 80 percent effective.

In Boulder, Colorado, nearly half the students in one school are not fully immunized, resulting in a resurgence of whooping cough in the immediate area this year.

Medicaid

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	63.99	68.75	59.23
<i>CUP</i>	411	62.29	67.09	57.48
<i>GHC</i>	432	78.7	82.68	74.73
<i>Kaiser</i>	87	82.76	91.27	74.25
<i>Molina</i>	453	66.67	71.12	62.22
<i>Premiera</i>	432	61.57	66.28	56.87
<i>Regence</i>	431	68.21	72.73	63.7
<i>State Median</i>	66.67			
<i>State Average</i>	69			

UCI/LCI rates are reported at the 95% confidence interval. See explanation earlier under "How are rates compiled?"

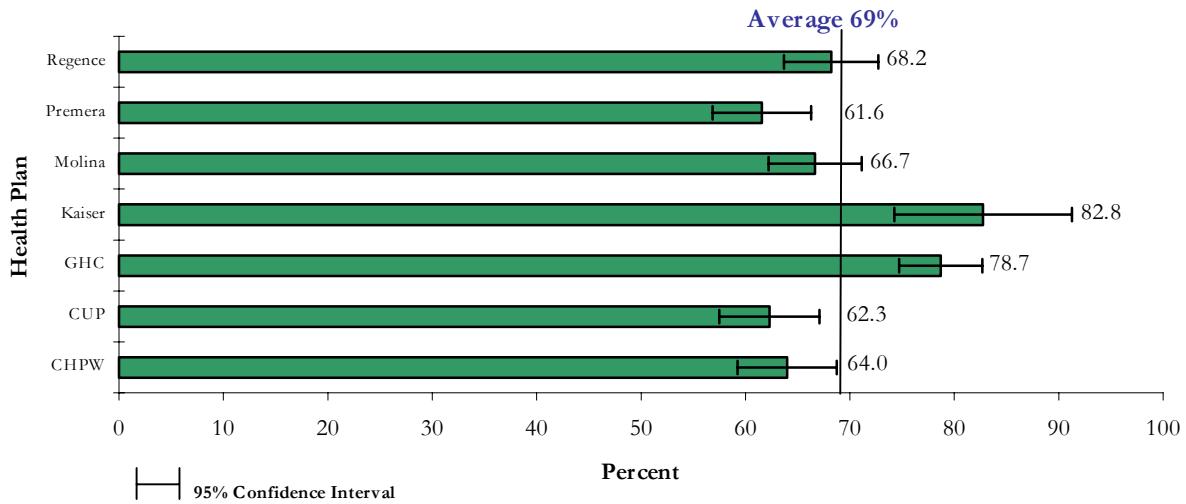
Analysis

Except for the Group Health Cooperative (GHC) rate, which improved slightly, all DTaP rates fell this year, including the statewide median rate (from 73 to 67 percent). Rates range from 62 percent for Premiera (PBC) to 83 percent (Kaiser). The statewide average is 69 percent.

Over a four-year period, the biggest change in the DTaP rate is Premiera (PBC) with a drop from 74 to 62 percent.

Vaccine shortage and declining immunization may have contributed to resurgence of whooping cough in Washington in 2002.

*Childhood Immunization - DTaP
Medicaid*



Measles, Mumps, and Rubella (MMR).

MMR is a combined vaccine with Measles, Mumps, and Rubella vaccines in a single injection.

Measles can cause pneumonia and about one in a thousand persons who contract measles will get encephalitis (infection of the brain that can result in deafness and mental retardation). Ninety percent of people not immune to measles will contract the virus if exposed. During the measles resurgence in the U.S, from 1989 to 1991, over 11,000 hospitalizations and 120 deaths were reported, resulting in \$100 million in direct medical costs. Measles is often imported from other countries where it is still endemic.

Mumps is a disease of the lymph nodes caused by a virus and can cause meningitis (infection of the lining of the brain) and permanent deafness.

Although rubella is a mild disease, it can cause birth defects if acquired by a pregnant woman. All children should be vaccinated to prevent transmission to pregnant women.

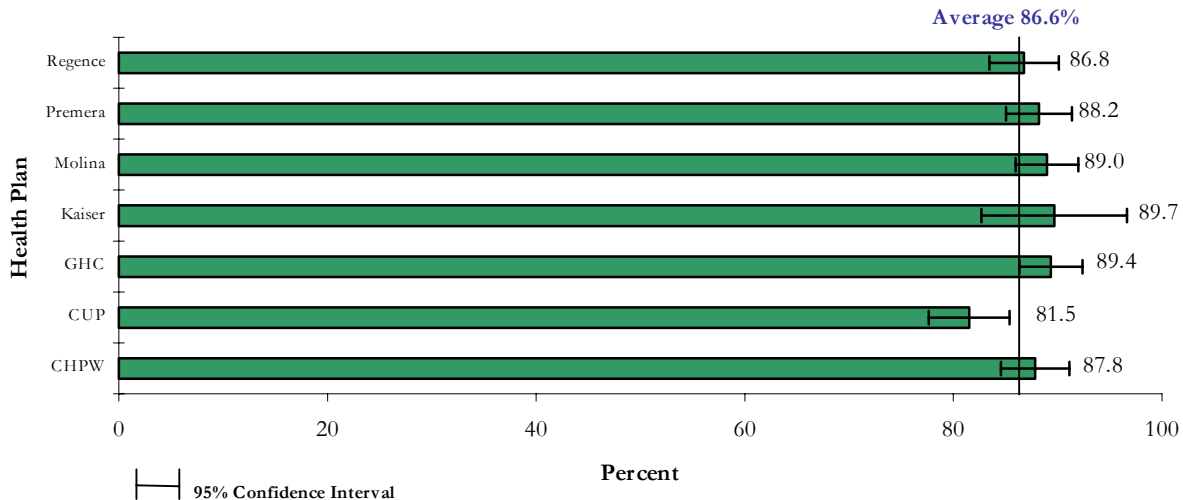
2002 Childhood Immunization - MMR

Medicaid

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	87.83	91.12	84.55
<i>CUP</i>	411	81.51	85.38	77.63
<i>GHC</i>	432	89.35	92.38	86.33
<i>Kaiser</i>	87	89.66	86.63	82.68
<i>Molina</i>	453	88.96	91.96	85.97
<i>Premera</i>	432	88.19	91.35	85.04
<i>Regence</i>	431	86.77	90.09	83.46
<i>State Median</i>	88.19			
<i>State Average</i>	86.6			

When measles hit King county in 2001, none of those contracting the disease were fully immunized. For more information, see the CDC website www.cdc.gov/nip or the DOH website www.doh.wa.gov/cfh/Immunize/immun_prog

Childhood Immunization - MMR
Medicaid



Analysis

Four MMR rates improved this year, while two dropped (CUP and Kaiser). Rates range from 82 percent (CUP) to 90 percent (Kaiser). The statewide median rose slightly (87 to 88 percent) and is above the average (87 percent). Since 1999, two rates improved (CHPW and GHC). Molina increased the MMR rate every year.

Inactivated Polio Vaccine (IPV).

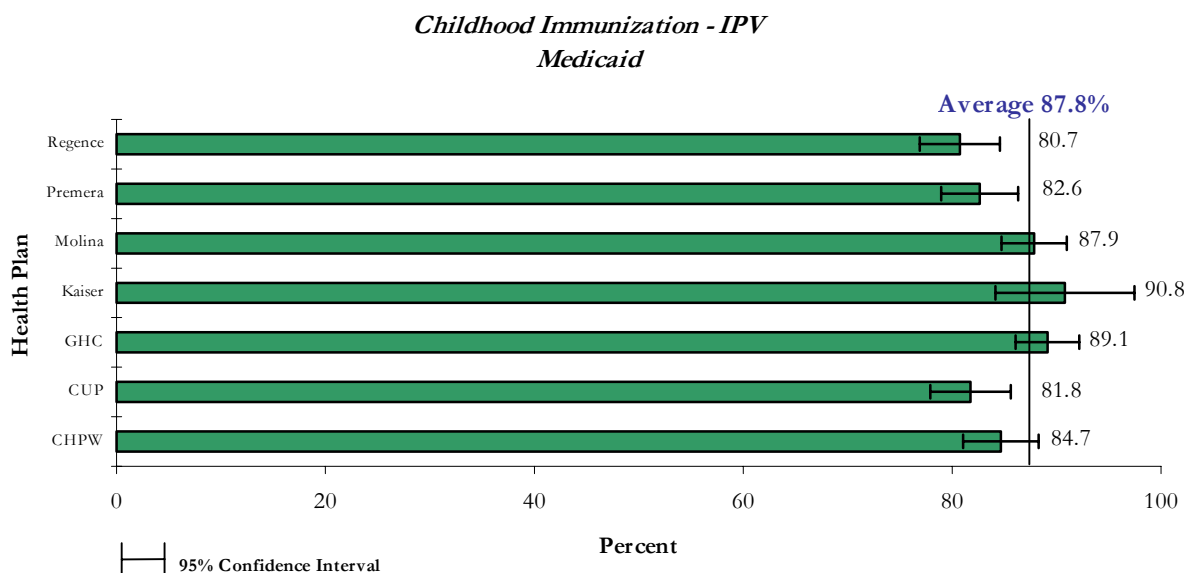
Poliomyelitis, a virus in the throat and intestinal tract that can cause paralysis, has been eliminated in this country since the epidemic of the 1950s, due to high vaccination levels. Because imported cases can transmit the disease, continued vaccination and surveillance are necessary. The ACIP no longer recommends the oral form of the vaccine.

2002 Childhood Immunization - IPV

Medicaid				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	84.67	88.28	81.07
<i>CUP</i>	411	81.75	85.61	77.9
<i>GHC</i>	432	89.12	92.17	86.07
<i>Kaiser</i>	87	90.80	97.45	84.16
<i>Molina</i>	453	87.86	90.98	84.74
<i>Premera</i>	432	82.64	86.33	78.95
<i>Regence</i>	431	80.74	84.58	76.9
<i>State Median</i>	84.67			
<i>State Average</i>	87.8			

Analysis

Five IPV rates improved; two dropped (CHPW and Regence). Rates range from 81 to 91 percent with an average rate of 88 percent. The median rate is about the same as last year (85 percent). Although PBC improved from last year, over a four-year period the PBC rate is the only rate that is lower this year (83percent) than in 1999 (85 percent) for this measure.



Hepatitis B (Hep B). Hep B is a viral infection causing liver disease. Vaccination is recommended for high-risk groups, including health care workers with exposure to blood and body fluids and for all infants. Hepatitis B becomes chronic in 90 percent of infants who contract the infection during childbirth, and 25 percent of those infected will die of related chronic liver disease as adults. Hep B is a reportable disease in Washington State, but many newly infected people are asymptomatic and not diagnosed.

The majority of newborns infected with Hep B during childbirth are preventable through

early prenatal screening, re-testing those at high risk late in pregnancy, and treating the infant at birth. Although thimerosal, a mercury based preservative alleged to cause autism and attention deficit hyperactivity disorder (ADHD) is no longer used in vaccines in the U.S., not all hospitals have resumed routine vaccination of newborns. A three-dose vaccine series is highly effective and universal immunization is recommended. More information is available at

www.CISPimmuniz.org/pro/pdf/Hep%20B%20guidance.pdf

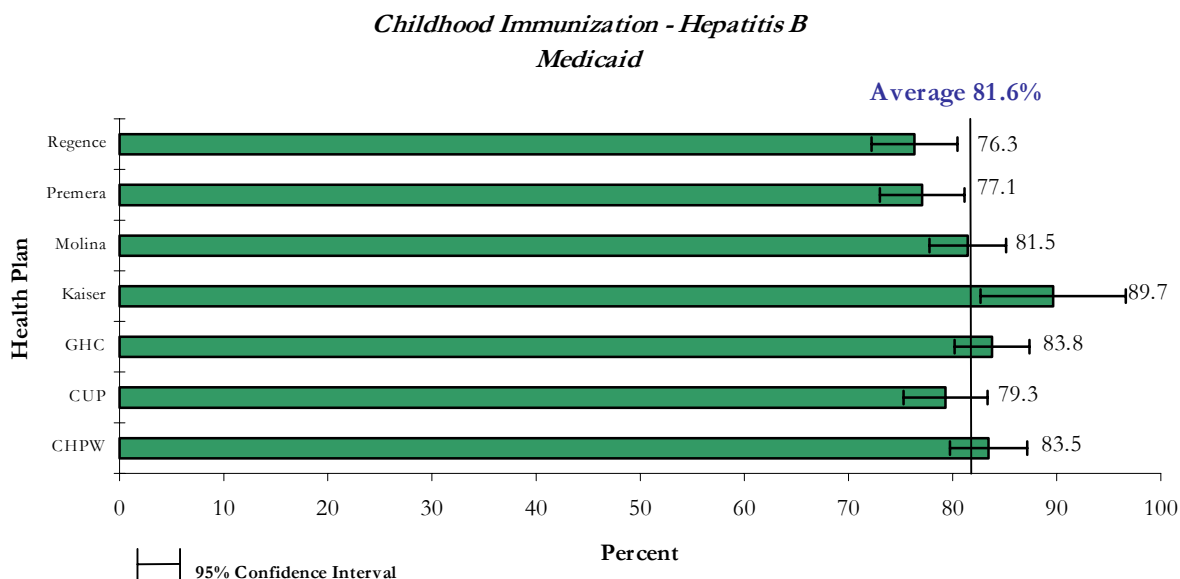
2002 Childhood Immunization - Hepatitis B

Plan	Medicaid			
	N	Rate (%)	UCI	LCI
CHPW	411	83.45	87.17	79.74
CUP	411	79.32	83.36	75.28
GHC	432	83.8	87.39	80.21
Kaiser	87	89.66	96.63	82.68
Molina	453	81.46	85.15	77.77
Premiera	432	77.08	81.16	73
Regence	431	76.33	80.46	72.21
State Median		81.46		
State Average		81.6		

Analysis

All Hep B rates except two improved. The median gained five percentage points (from 77 to 82 percent). Rates range from 76 (Regence) to 90 percent (Kaiser). The average rate is 82 percent.

Over a four-year period, CHPW has the most significant improvement, with a 21 percentage point increase (from 63 percent in 1999 to 84 percent this year). The four-year statewide median rate gained ten percentage points (from 72 to 82 percent).



Haemophilus influenza type B (HiB). HiB causes meningitis and can cause permanent brain damage. It can also cause swelling of the throat and lead to suffocation, and infection of joints, bones, and lungs. HiB vaccines are highly effective. Most HiB disease today strikes infants who are not immunized.

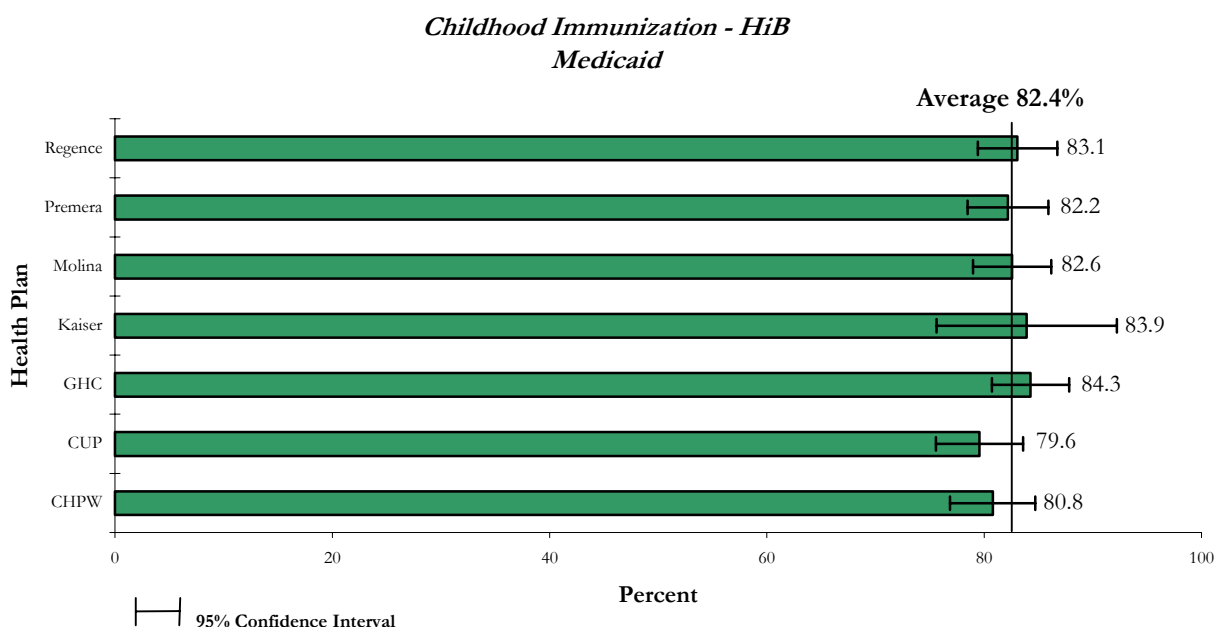
2002 Childhood Immunization - HiB

Plan	Medicaid			
	N	Rate (%)	UCI	LCI
CHPW	411	80.78	84.71	76.85
CUP	411	79.56	83.58	75.54
GHC	432	84.26	87.81	80.71
Kaiser	87	83.91	92.2	75.61
Molina	453	82.56	86.17	78.96
Premiera	432	82.18	85.9	78.45
Regence	431	83.06	86.72	79.41
State Median	82.56			
State Average	82.4			

Analysis

Five HiB rates improved; two dropped (Kaiser and Molina). There is little variance among health plans on this measure—from 80 percent (CUP) to 84 percent (Kaiser). The median rate increased from 80 to 83 percent and is nearly the same as the average.

For HiB over the past four years, CUP gained six percentage points and CHPW gained three. Molina gained ten percentage points in three years (from 73 to 83 percent). The four-year median improved from 79 percent in 1999 to 83 percent this year.



Varicella (VZV). Varicella, also called Chickenpox, is a virus that can lead to serious skin infection, pneumonia and

In the June 13, 2003 issue of Morbidity and Mortality Weekly Report, the CDC describes two of nine fatal cases of Varicella reported in 2002. Both were previously healthy but unvaccinated and exposed to unvaccinated children with chickenpox.

meningitis. Deaths due to chickenpox continue to occur. Although Varicella can be severe in infants, it is usually a more severe disease among adolescents and adults. The highest incidence is among elementary school aged children. In the average household, a child with chicken pox misses 5-6 days of school, and adults

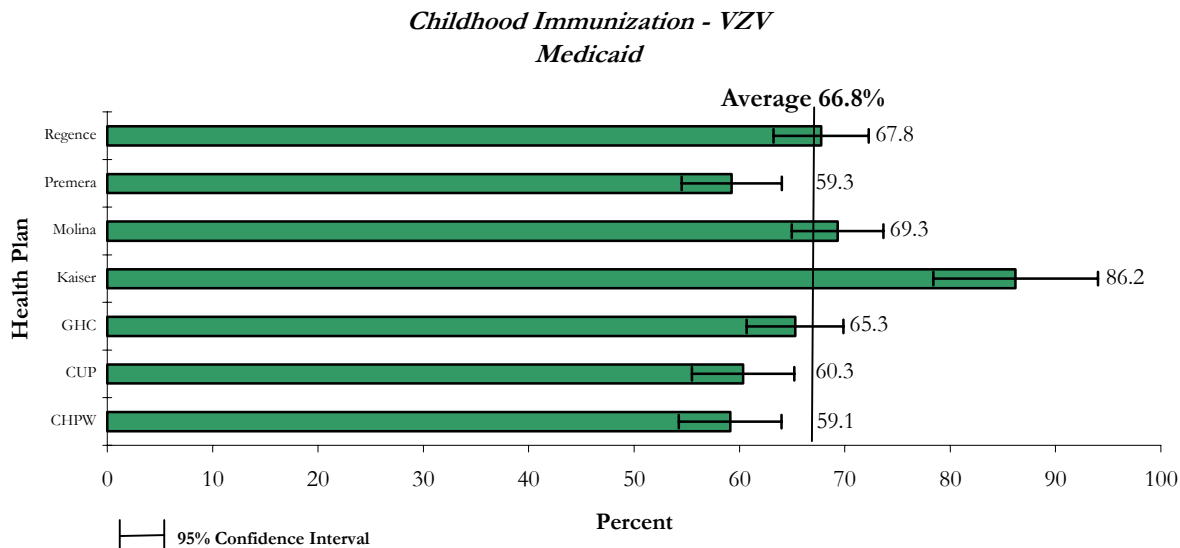
lose up to 3-4 days of work to care for them. Vaccination for VZV has been available since 1995 and is up to 95 percent effective.

2002 Childhood Immunization - VZV

<i>Plan</i>	<i>Medicaid</i>			
	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	59.12	64	54.25
<i>CUP</i>	411	60.34	65.19	55.49
<i>GHC</i>	432	65.28	69.88	60.67
<i>Kaiser</i>	87	86.21	94.03	78.39
<i>Molina</i>	453	69.32	73.67	64.96
<i>Premiera</i>	432	59.26	64.01	54.51
<i>Regence</i>	431	67.75	72.28	63.22
<i>State Median</i>	65.28			
<i>State Average</i>	66.8			

Analysis

All VZV rates improved this year, including the median, which increased from 55 to 65 percent. Rates range from 59 percent (CHPW) to 86 percent (Kaiser). Over the four year period from 1999 to 2002, CHPW has the largest improvement, with an increase from nine to 59 percent—a gain of fifty percentage points. Others gained 30 to 40 percentage points and the median rate improved from 20 percent in 1999 to 65 percent this year (45 percentage points).



Combination 1 (Comb 1). NCQA uses combination measures as an aggregate rate for universally recommended childhood immunizations. Changes in the specifications for Comb 1 over the years, though, require adjustments for trending.

Analysis

Only the Regence Comb 1 rate improved this year. Although all the childhood immunization rates except DTaP improved, the median Combination 1 rate decreased three percentage points this year. The average, though, is 61 Percent; GHC and Kaiser are significantly above the average; Premera is significantly below the average.

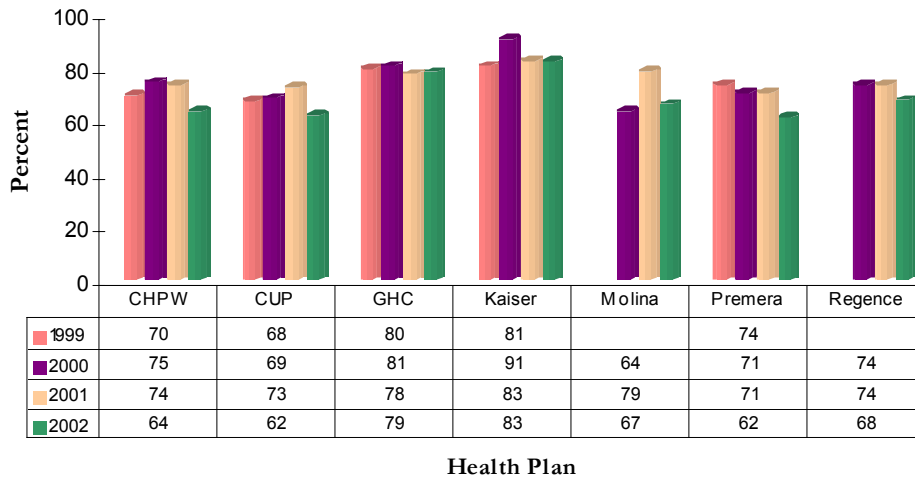
Over a four-year period, two health plans have significant rate changes. The CUP Comb 1 rate increased from 48 percent in 1999 to 56 percent in 2002, and the PBC rate dropped from 62 percent in 1999 to 51 percent in 2002.

2002 Childhood Immunization - Comb 1

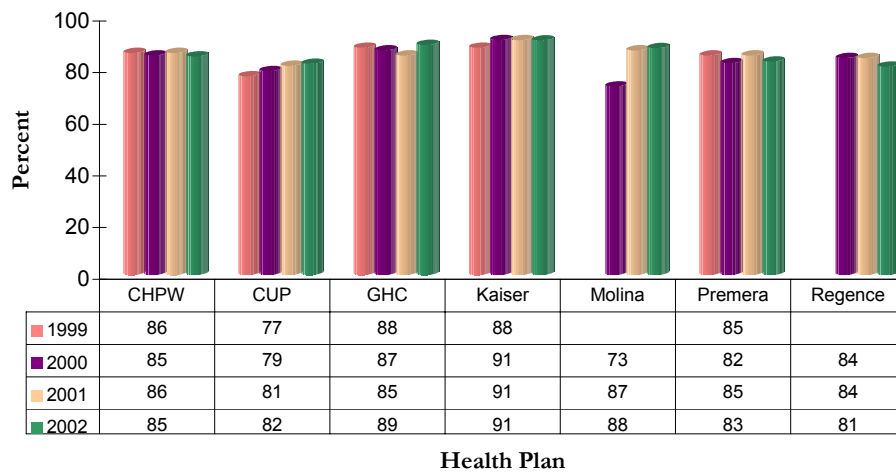
<i>Medicaid</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	56.2	61.12	51.29
<i>CUP</i>	411	55.47	60.4	50.55
<i>GHC</i> ↑	432	69.91	74.35	65.47
<i>Kaiser</i> ↑	87	78.16	87.42	68.9
<i>Molina</i>	453	56.29	60.97	51.61
<i>Premera</i> ↓	432	50.46	55.29	45.63
<i>Regence</i>	431	58.24	63.01	53.46
<i>State Median</i>	56.29			
<i>State Average</i>	60.7			
<i>Healthy People 2010</i>	90			

Childhood Immunization - Multi Year Comparisons

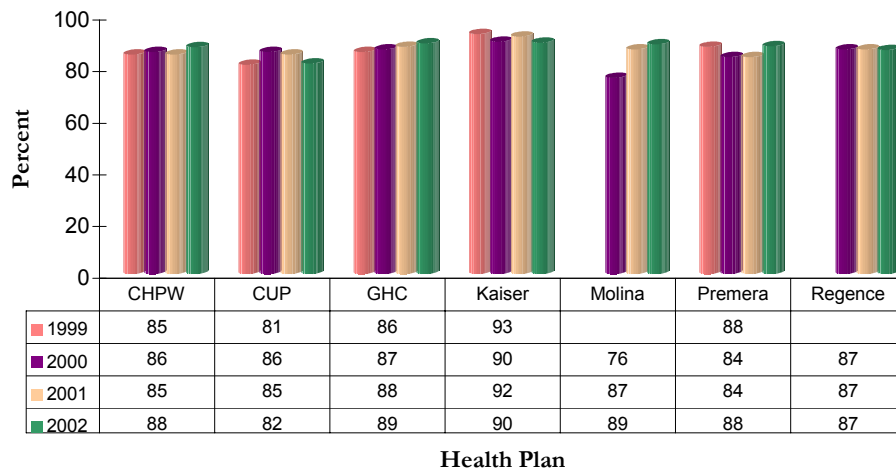
Medicaid Childhood Immunization - DTaP



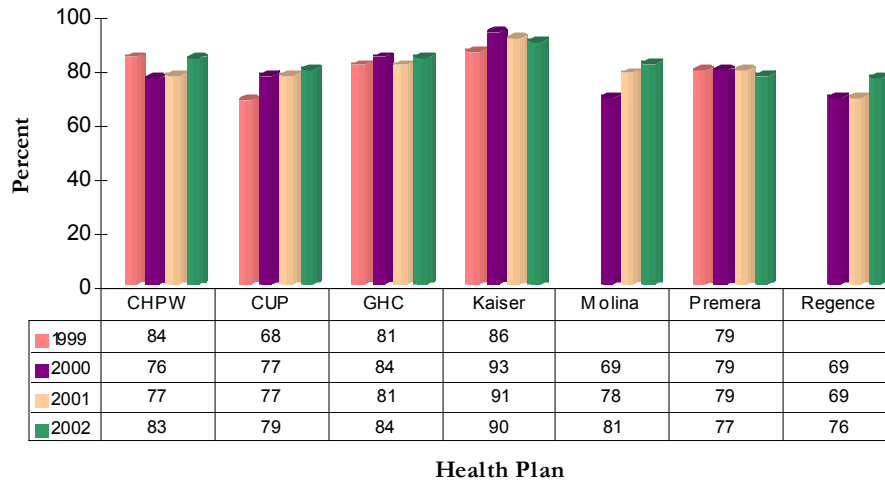
Medicaid Childhood Immunization - IPV



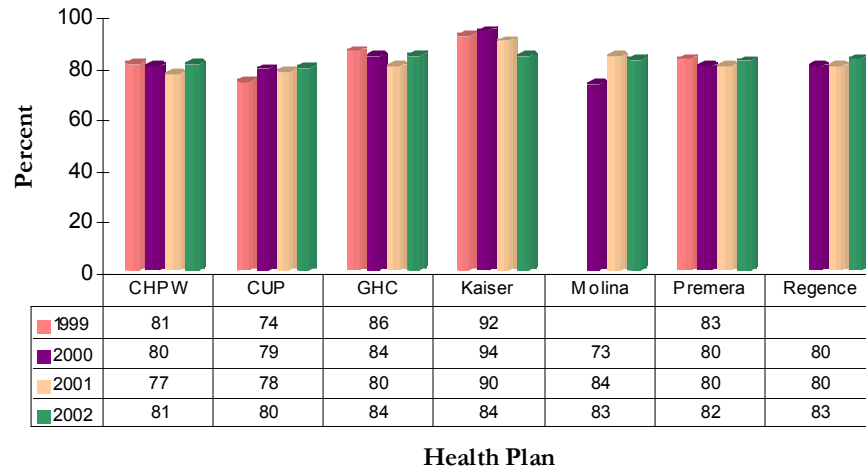
Medicaid Childhood Immunization - MMR



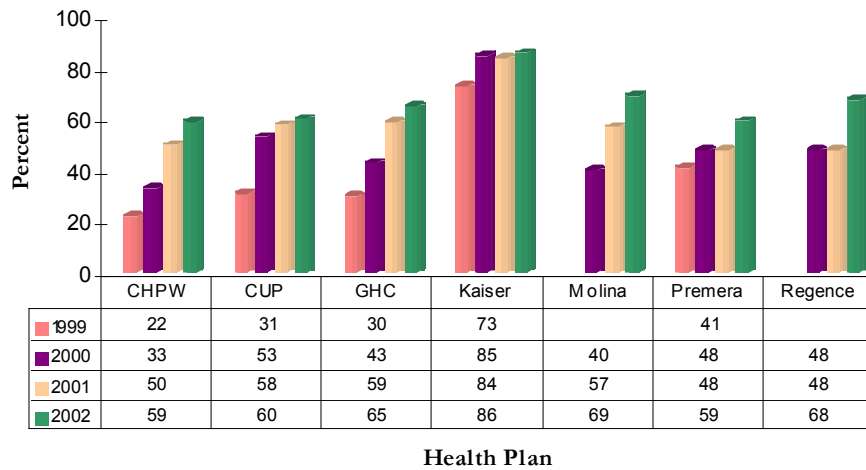
Medicaid Childhood Immunizations - Hepatitis B

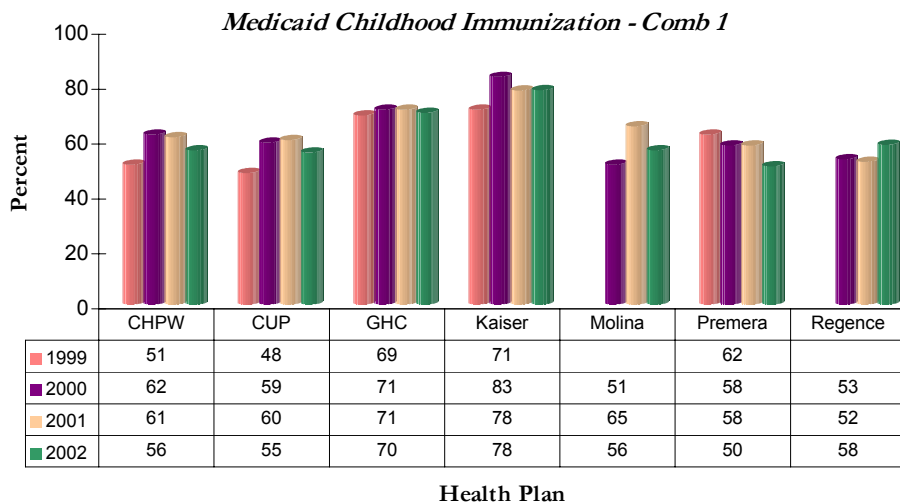


Medicaid Childhood Immunization - Hib



Medicaid Childhood Immunization - VZV





What the rates mean

Washington has liberal childhood immunization exemption laws, which allow parents to exempt a child by checking a box on a school form. Compared to a one percent rate nationally, the Washington exemption rate is over four percent. Pockets of communities across Washington have high exemption rates, such as Ferry County, with 46 percent. In some private schools vaccination is the exception.

National shortages of vaccines continue—some widespread and others localized. Shortages caused temporary changes in the recommended vaccination schedules, such as delaying the fourth dose of DTap, and is probably reflected in the 2002 rates.

In addition to vaccine shortages, public confidence in vaccine safety likely influenced immunization rates. In recent years, concerns about adverse effects of childhood immunization, including autism, seizures and crib death, have been widely discussed in the news media. A popular parent's

magazine characterized vaccine safety as "the great unanswered question in medicine today." Further, more than a dozen Internet sites, including one by a Washington parent, now specialize in describing the dangers of vaccination. Largely as a result of media, more parents question the safety of vaccines and have decided against having their children immunized, or pick and choose just the vaccines they feel are necessary.

The IOM conducted exhaustive studies on vaccine safety in 1991 and 1994, and reopened hearings on vaccine safety based on new anti-immunization campaigns and rallies against a 2002 decision in Congress to make it harder to sue vaccine makers.

Because of the success of vaccines in reducing incidents of Vaccine Preventable Diseases (VPD), rates of diseases are so low in the U.S. that reports of adverse events related to vaccines (approximately 11,000 per year) now outnumber reports of VPDs (approximately 8,000 per year).

Vaccine safety surveillance to detect rare or delayed adverse effects is maintained in the U.S. through the Vaccine Adverse Event Reporting System (VAERS) and the Vaccine Safety Datalink

(VSD) project. Studies about adverse effects often show conflicting results. The ACIP addressed vaccine safety, shortages and temporary changes in vaccine recommendations in a recently released

35-page report, *General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices and the American Academy of Family Physicians*, available on the CDC website at www.cdc.gov/nip

The HEDIS Combination 1 rate lags behind figures in the National Immunization Survey (NIS) for the state of Washington. The NIS data and *Healthy People 2010* include children from age 19 months to 35 months of age, whereas the HEDIS age specification is birth to 24 months. This difference may explain why the national rate is higher than the HEDIS rate, since in most states children are required to have up-to-date

immunizations prior to entering preschool around age 3. *The State of Washington's Children - Summer 2002* cites the overall state immunization rate for children (includes children not in managed care) at 71 percent in 2000. The report does not specify the age range.

An AAP paper "Study Fails to Demonstrate a Connection Between Thimerosal and autism," available at www.CISPimmuniz.org/pro/pdf/Geiersummary.pdf, advises clinicians about conceptual and scientific flaws, omissions of fact, inaccuracies and misstatements in a recent study.

PRENATAL AND POSTPARTUM CARE

Why this measure is important

The American College of Obstetricians and Gynecologists (ACOG) recommends that prenatal care for women begin in the first trimester of pregnancy.

Early and adequate prenatal care can identify mothers at risk of delivering preterm and address known modifiable risk factors, including nutrition, infection, psychological stress, tobacco, alcohol and drug use. Low-income mothers are less likely to obtain timely prenatal care and more likely to have low birth weight babies. More than a third of the births in Washington are paid by Medicaid.

Costs for low birth weight infants are high, including neuro-developmental handicaps, congenital anomalies and respiratory illnesses. Low birth weight is also associated with greater emotional problems through childhood. The National Conference of State Legislatures declared that prenatal care saves future health care and educational system costs for children born with preventable learning disabilities. According to research by the National Institute of Health (NIH), adequate prenatal care varies across demographic groups and many of the risk factors disproportionately affect certain racial and ethnic groups.

The *Healthy People 2010* goal for early prenatal care is 90 percent.

A recent national study found the greatest rise in the percentage of pregnant women receiving early prenatal care in the past decade was among Black women, although they remain well below the rate for Whites.

The American College of Obstetricians and Gynecologists (ACOG) recommends a postpartum visit, including a physical examination and appropriate counseling between four and six weeks after delivery. The purpose of the postpartum visit is to evaluate the condition of the mother, answer questions and provide guidance. In addition to physical, emotional and social changes, up to thirteen percent of new mothers

become severely clinically depressed. Prompt recognition and treatment can reduce both the duration and the effects of postpartum depression. One of the strongest predictors of postpartum depression is prenatal depression or anxiety. Providers who recognize the symptoms and refer these women for treatment prior to delivery can prevent postpartum depression.

Description

The Prenatal and Postpartum Care measure is a composite and uses one eligible population for the denominator. The Prenatal Care measure counts women who delivered a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year, and were continuously enrolled in the same health plan at least 43 days prior to delivery through 56 days after delivery. The measure calculates the percentage of eligible woman who began prenatal care during the first 13 weeks of pregnancy, or within 43 days of enrolling if the woman enrolled after 13 weeks.

The Postpartum Care measure is the percentage of women with live births who have a postpartum visit between 21 and 56 days after delivery.

2002 Timeliness of Prenatal Care

Medicaid

Plan	N	Rate (%)	UCI	LCI
CHPW	411	87.83	91.12	84.55
CUP ↓	411	84.67	88.28	81.07
GHC	432	87.50	90.73	84.27
Kaiser	47	91.49	100	82.45
Molina ↑	453	93.16	95.59	90.72
Premiera ↑	425	92.71	95.3	90.12
Regence	432	86.34	89.7	82.99
State Median	87.83			
State Average	89.1			

2002 Postpartum Care

Medicaid

Plan	N	Rate (%)	UCI	LCI
CHPW	411	55.72	60.64	50.79
CUP ↓	411	53.77	58.71	48.83
GHC ↑	432	68.52	73.01	64.02
Kaiser	47	65.96	80.57	51.35
Molina	453	61.37	65.96	56.77
Premiera	425	60.47	65.24	55.7
Regence ↑	432	69.44	73.9	64.98
State Median	61.37			
State Average	62.2			

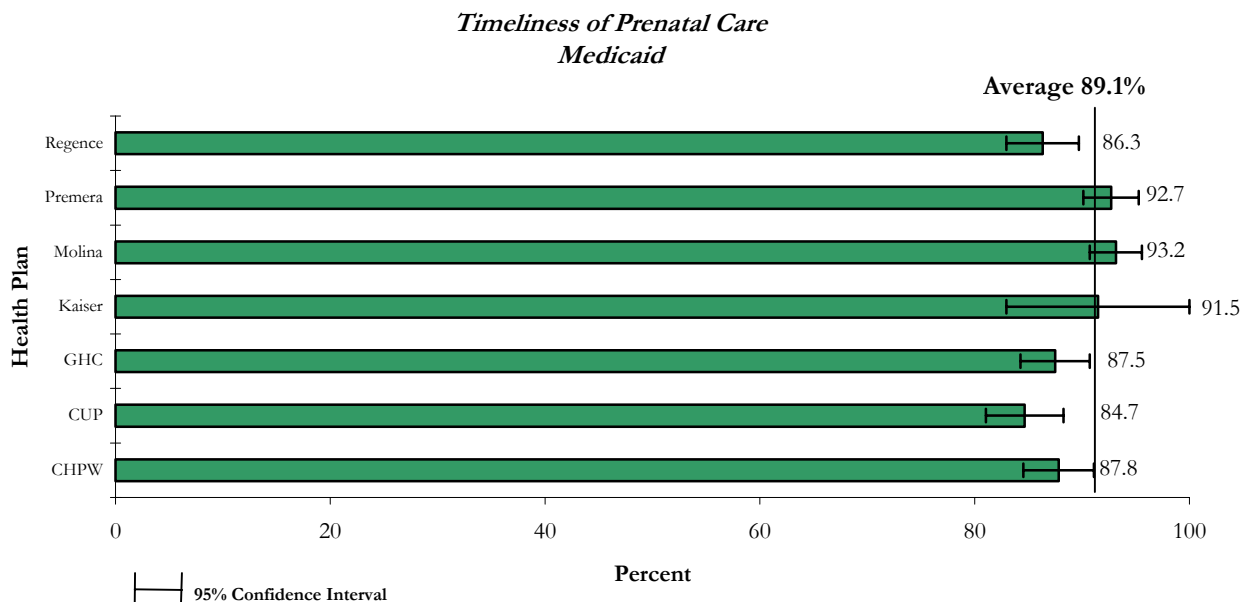
Analysis

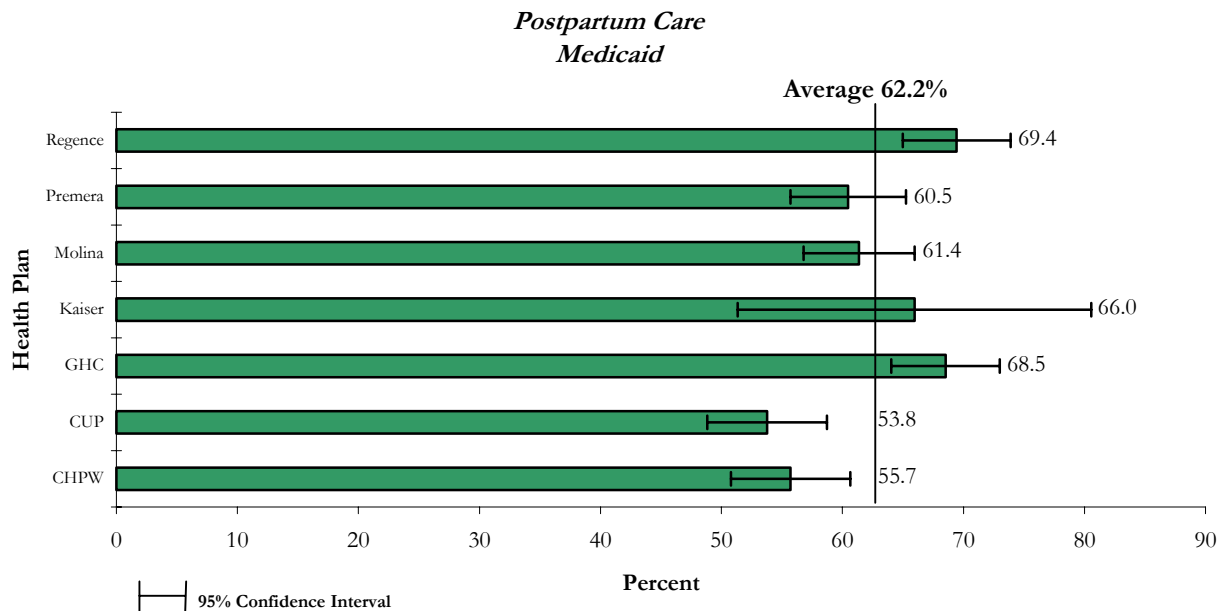
Five prenatal care rates improved this year. Three are above the *Healthy People 2010* benchmark of 90 percent: PBC and Molina (93 percent), and Kaiser (91 percent). CUP (85 percent) is significantly below the statewide average. The statewide median dropped from 89 to 88 percent this year.

NCQA changed this measure in 2000. Although specifications for enrollment differ from the earlier measure, they are sufficiently similar to include the rates in statewide aggregate trending. Over a four-year period, the statewide median for this measure improved significantly (from 68 to 88 percent).

According to a national assessment published in the "Kids Count" annual report, Washington is among three states with the lowest proportion of low birth weight babies, and the infant mortality rate fell from almost eight percent in 1990 to five percent in 2000. Improving prenatal care rates may account, in part, for these findings.

Three postpartum care rates improved and the median increased from 57 to 61 percent. Four rates dropped (CHPW, CUP, Kaiser, and Regence). Although the Regence rate dropped, it remains the highest and along with the GHC rate is significantly above the statewide average of 62 percent.





What the rates mean

Prenatal care rates are a measure of access to women's health care. Outcome measures for inadequate prenatal care, such as low birth weight, are strongest for high-risk groups (teens and low-income women).

In Washington, the low birth rate is significantly higher in Black, Native American, and Asian Pacific Islander babies than in Whites. The rate is also higher for women receiving Medicaid services than for women not receiving Medicaid.

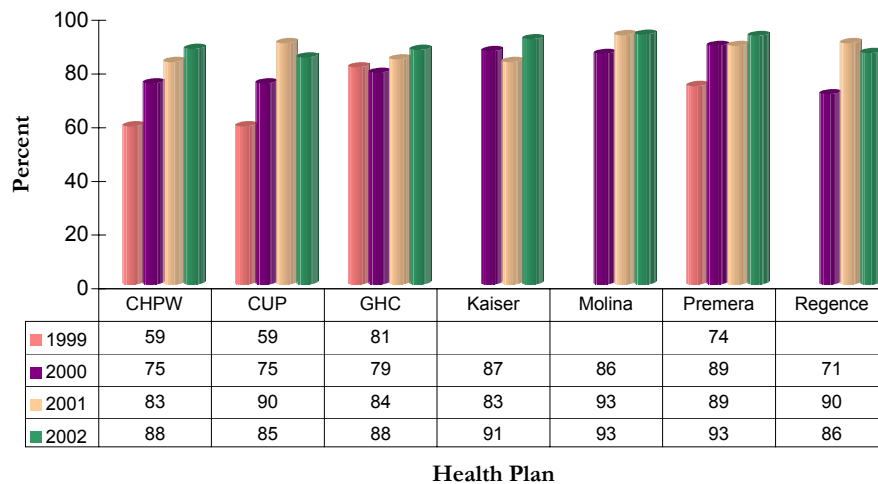
For continuity of care, a pregnant woman enrolled in a Medicaid managed care plan is guaranteed access to her established prenatal

care provider until delivery, even when the provider is not participating with the health plan. HEDIS rates may not reflect all prenatal care visits if medical records for care delivered outside the provider network are not sent to the health plan.

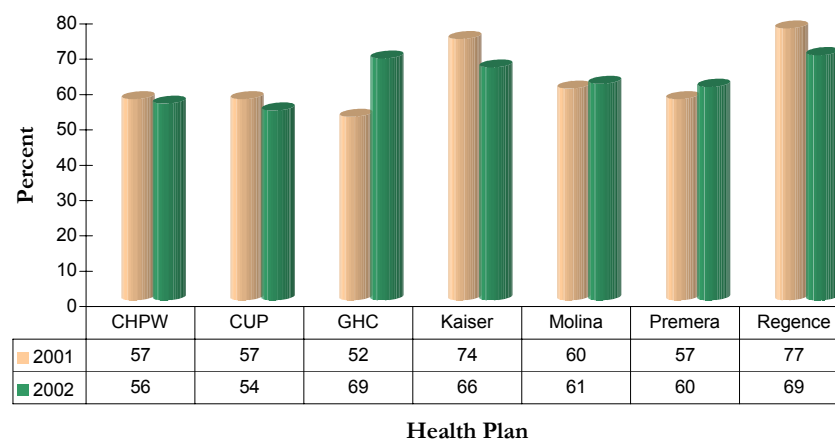
The postpartum care measure was a required measure beginning in 2001 (for services delivered in 2000). Although the postpartum care measure aligns with ACOG recommendations, the HEDIS rate may undercount actual postpartum care visits, since visits within 20 days after delivery or earlier do not count in the rate.

Prenatal and Postpartum Care – Multi Year Comparison

Medicaid Timeliness of Prenatal Care



Medicaid Postpartum Care



WELL CHILD AND ADOLESCENT CARE

Why these rates are important

The World Health Organization defines health as "a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity." The goal of preventive care visits is to achieve or maintain optimal health.

Well child visits provide opportunities for primary care providers to detect physical, developmental, behavioral and emotional problems, provide treatment, and assess immunization status. Risk factors and risk-related behaviors for chronic conditions can be detected in discussions during routine physical exams. Regular check-ups also provide an opportunity for the clinician to offer guidance and counseling to parents, which is particularly important during the first year of life, when an infant undergoes substantial changes in physical, mental and social growth, motor skills, and hand-eye coordination. The AAP recommends six well-child visits in the first year of life.

Over 25 million children in the U.S. have health coverage through Medicaid. Early periodic screening, diagnosis, and treatment (EPSDT) services are mandated under federal regulations for children in Medicaid programs from birth to age 21. EPSDT includes a comprehensive package of preventive, diagnostic and treatment services, health counseling and guidance, and support services such as transportation and translation services.

Coverage alone, however, does not guarantee that services will be available or that children will receive needed care.

MAA requires contracted health plans to provide EPSDT services, which are based on the AAP health supervision guidelines. HEDIS well child and adolescent care visit measures are based on the same guidelines as EPSDT. Detailed explanation of what constitutes a well child visit are available at www.brightfutures.org

A recent three-year study conducted on children enrolled in Medicaid found they use fewer preventive services, more emergency services, and have higher hospitalization rates and more serious exacerbations of conditions that are treatable in office settings than children not enrolled in Medicaid. Reported in *Pediatrics*, the study concluded that maintaining well child care visits in the first two years of life is associated with a decrease in avoidable hospitalization among poor and near-poor children. While other studies are consistent with these findings, research findings are mixed on the correlation between more preventive care and reduced acute or long-term health care costs. Other studies that examine use of preventive health services suggest that state programs and availability of resources are the most important predictors of preventive health service utilization.

Child population growth in Washington (20 percent) exceeded the national average (14 percent) over the past ten years and in three counties, children comprise more than 50 percent of the population. Diversity has increased significantly, with Asian/Pacific Islander children up 35 percent and Black children up 16 percent, whereas the number of White children increased by only six percent.

WELL CHILD VISITS IN THE FIRST 15 MONTH OF LIFE

Description of the measure

The Well Child Visits in the First 15 Months of Life measure is the percent of members who turned 15 months old during the reporting year, who were enrolled from 31 days of age (allowing a one month gap in enrollment) and who received 0-6 or more preventive care visits with a Primary Care Provider during their first 15 months of life. A child is included in only one numerator (i.e., a child receiving six well-child visits is not included in the rate for five, four, or fewer visits).

The HEDIS well child visit measure looks at the adequacy of well-child care for infants and separately measures the percentage of eligible children with no visits to six or more visits by 15 months of age. Hospital, emergency department, and specialist visits are not counted.

Specifications for visits are generally accepted age-appropriate standards of practice, including a health and developmental history, physical exam, and health education/anticipatory guidance.

The administrative method assumes the provider follows accepted practice guidelines for preventive care and appropriate coding protocols. Chart review (the hybrid method) can verify adherence to practice guidelines.

2002 Well Child Birth to 15 Mo. - 0 visits

<i>Medicaid</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	2.19	3.73	0.65
<i>CUP</i>	411	2.43	4.04	0.82
<i>GHC</i>	432	1.16	2.28	0.03
<i>Kaiser</i>	48	2.08	7.17	0
<i>Molina</i>	453	1.55	2.79	0.3
<i>Premiera</i>	965	6.84	8.48	5.19
<i>Regence</i>	288	4.51	7.09	1.94
<i>State Median</i>	2.19			
<i>State Average</i>	3			

2002 Well Child Birth to 15 Mo - 1 visit

<i>Medicaid</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	4.87	3.73	0.65
<i>CUP</i>	411	2.92	4.04	0.82
<i>GHC</i>	432	2.08	3.55	0.62
<i>Kaiser</i>	48	4.17	10.86	0
<i>Molina</i>	453	1.77	3.09	0.44
<i>Premiera</i>	965	6.11	7.68	4.55
<i>Regence</i>	288	17.71	22.29	13.13
<i>State Median</i>	2.43			
<i>State Average</i>	5.7			

2002 Well Child Birth to 15 Mo - 2 visits

<i>Medicaid</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	6.33	8.8	3.85
<i>CUP</i>	411	4.14	6.18	2.09
<i>GHC</i>	432	2.55	4.15	0.95
<i>Kaiser</i>	48	12.5	22.9	2.1
<i>Molina</i>	453	4.42	6.42	2.41
<i>Premiera</i>	965	8.91	10.76	7.06
<i>Regence</i>	288	19.44	24.19	14.7
<i>State Median</i>	6.33			
<i>State Average</i>	8.4			

2002 Well Child Birth to 15 Mo - 3 visits

<i>Medicaid</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	8.27	11.06	5.49
<i>CUP</i>	411	9.98	12.99	6.96
<i>GHC</i>	432	10.65	13.67	7.62
<i>Kaiser</i>	48	0	1.04	0
<i>Molina</i>	453	7.06	9.53	4.59
<i>Premiera</i>	965	14.2	16.45	11.94
<i>Regence</i>	288	18.75	23.43	14.07
<i>State Median</i>	9.98			
<i>State Average</i>	9.9			

2002 Well Child Birth to 15 Mo - 4 visits

<i>Medicaid</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	14.36	17.87	10.84
<i>CUP</i>	411	15.33	18.93	11.72
<i>GHC</i>	432	17.82	21.55	14.1
<i>Kaiser</i>	48	6.25	14.14	0
<i>Molina</i>	453	12.36	15.5	9.22
<i>Premiera</i>	965	29.43	32.36	26.5
<i>Regence</i>	288	12.85	16.89	8.81
<i>State Median</i>	14.36			
<i>State Average</i>	15.5			

2002 Well Child Birth to 15 Mo - 5 visits

2002 Well Child Birth to 15 Mo - 6 visits

Medicaid

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	23.36	27.57	19.15
<i>CUP</i>	411	27.25	31.68	22.82
<i>GHC</i>	432	34.95	39.59	30.34
<i>Kaiser</i>	48	18.75	30.83	6.67
<i>Molina</i>	453	27.15	31.36	22.95
<i>Premiera</i>	965	26.53	29.37	23.69
<i>Regence</i>	288	11.11	14.91	7.32
<i>State Median</i>	26.53			
<i>State Average</i>	24.2			

Medicaid

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	40.63	45.5	35.76
<i>CUP</i>	411	37.96	42.77	33.14
<i>GHC</i>	432	30.79	35.26	26.32
<i>Kaiser</i>	48	56.25	71.33	41.17
<i>Molina</i>	453	45.7	50.39	41
<i>Premiera</i>	965	7.98	9.74	6.22
<i>Regence</i>	288	15.63	19.99	11.26
<i>State Median</i>	37.96			
<i>State Average</i>	33.6			

Analysis

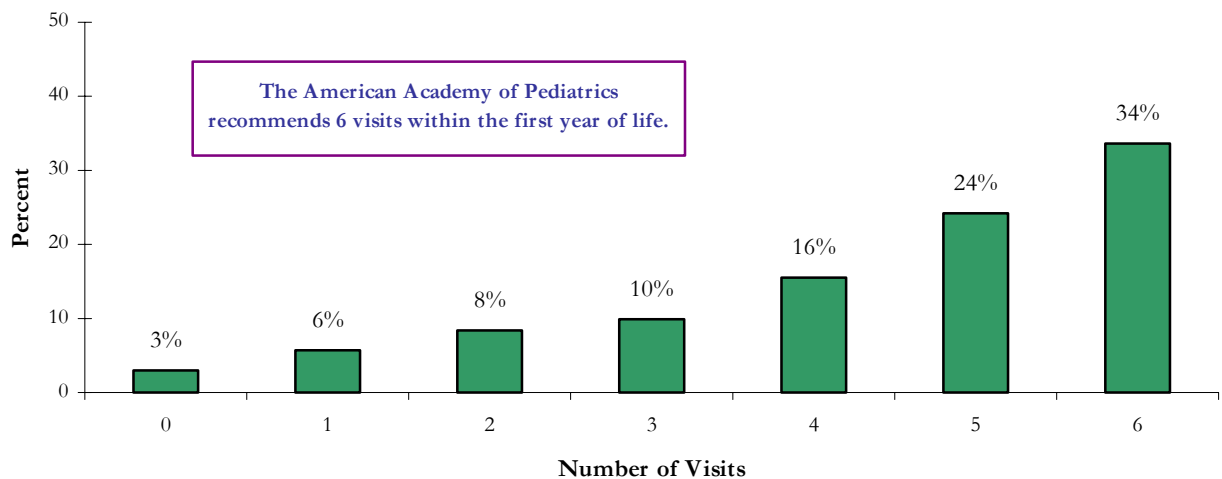
The average rate of eligible infants with no preventive care visits is three percent. Across health plans, one percent (GHC) to seven percent (PBC) of eligible infants did not receive any well child care visits in the first 15 months of life.

On average, six percent of eligible infants had only one visit; rates range from two (Molina) to 18 percent (Regence). The average rate for two visits is eight percent with rates ranging from three (GHC) to 19 percent (Regence). For three visits, the average rate is ten percent, and the range is from 0 (Kaiser) to 19 percent (Regence). Rates for infants receiving four visits range from six (Kaiser) to 29 percent (PBC) and the average rate is 16 percent.

About 24 percent of eligible infants received five visits. The statewide average for infants who received all six of the recommended well child visits is 34 percent, with a wide variance among health plans—from eight percent (PBC) to 56 percent (Kaiser). At least half the eligible infants are getting five or more visits in all health plans except in PBC (36 percent) and Regence (27 percent).

The "Kids Count" report released in June this year provides state and national comparison on ten categories. The report ranked states on every measure and gave a composite ranking based on all ten. Washington ranked 38th in the composite.

***2002 Statewide Average Medicaid Well Child Visits
Birth to 15 Months***



WELL CHILD VISITS IN THE 3RD, 4TH, 5TH, AND 6TH YEARS OF LIFE

Description

The percentage of members three, four, five or six years old during the measurement year, who were continuously enrolled during the measurement year and who received one or more well-child visit(s) with a primary care practitioner during the measurement year.

This measure assesses the percentage of preschool and early school aged children between three and six years old who had at

least one well-child visit with a primary care practitioner during the measurement year.

The AAP recommends annual well-child visits for two to six year olds. Well child visits during the pre- and early school years are particularly important to detect vision, speech and language problems. Early intervention can improve communication skills and avoid or reduce language and learning problems.

2002 Well Child Visits (3-6 years)

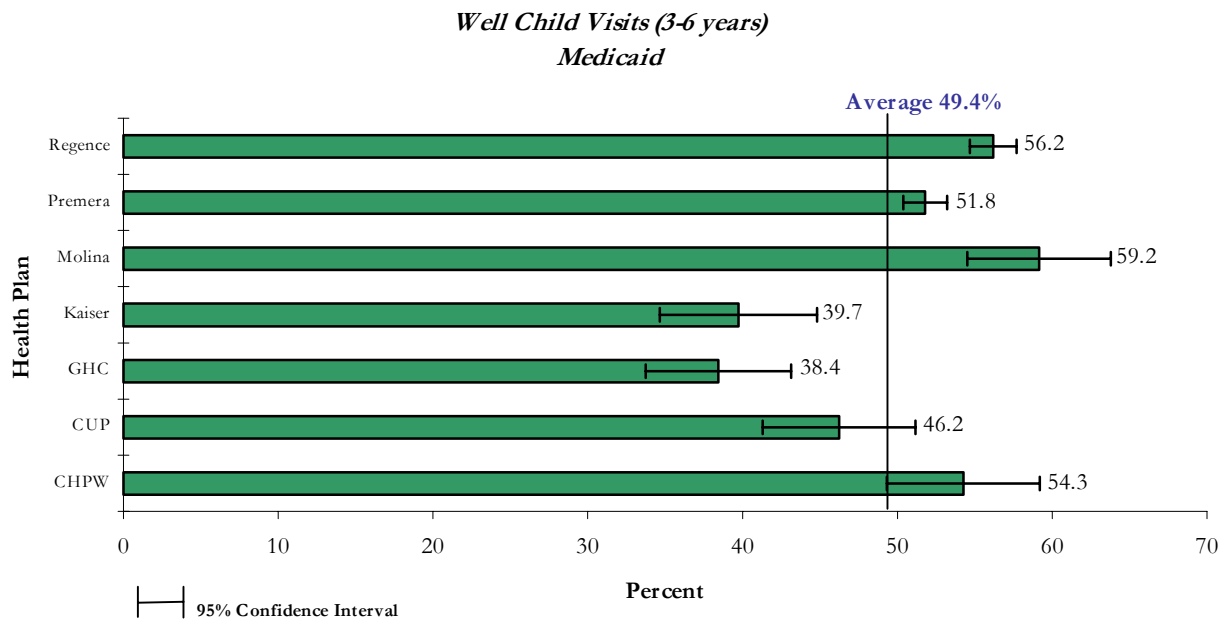
Medicaid

Plan	N	Rate (%)	UCI	LCI
CHPW	411	54.26	59.2	49.32
CUP	411	46.23	51.17	41.29
GHC	432	38.43	43.13	33.72
Kaiser	375	39.73	44.82	34.65
Molina	453	59.16	63.8	54.52
Premiera	4858	51.79	53.21	50.38
Regence	4212	56.2	57.71	54.69

State Median	51.79
State Average	49.4

Analysis

Well child care visit rates for this age group ranged from 38 percent (GHC) to 59 percent (Molina). The statewide average rate is 49 percent.



ADOLESCENT WELL CARE VISITS

Description

The percentage of enrolled members who were 12-21 during the measurement year, who were continuously enrolled during the measurement year and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

This measure reports the percentage of adolescents from age 12 to 21 who had at least one well-care visit with a primary care provider, obstetrician or gynecologist during the measurement year.

Adolescence is a period of profound change. More changes take place in anatomy, physiology, mental, emotional, and social development during adolescence than in any other life stage except infancy.

Comprehensive annual well care visits provide an opportunity to address these changes and avert negative health consequences. Medicaid benefits include well care visits for adolescents up to age 21. Medical Association Guidelines for Adolescent Preventive Services, the Bright Futures program, and the AAP guidelines all recommend comprehensive annual check ups for adolescents.

2002 Adolescent well care

Medicaid

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>CHPW</i>	411	34.79	39.52	30.07
<i>CUP</i>	411	27.74	32.19	23.29
<i>GHC</i>	125	31.48	35.98	26.99
<i>Kaiser</i>	636	35.06	38.85	31.28
<i>Molina</i>	453	42.83	47.49	38.16
<i>Premiera</i>	9762	33.88	34.82	32.93
<i>Regence</i>	4566	38.52	39.95	37.1

<i>State Median</i>	34.79
<i>State Average</i>	34.9

Analysis

The rates for adolescent well care visits ranged from 28 percent (CUP) to 43 percent (Molina). The statewide average rate is 35 percent.

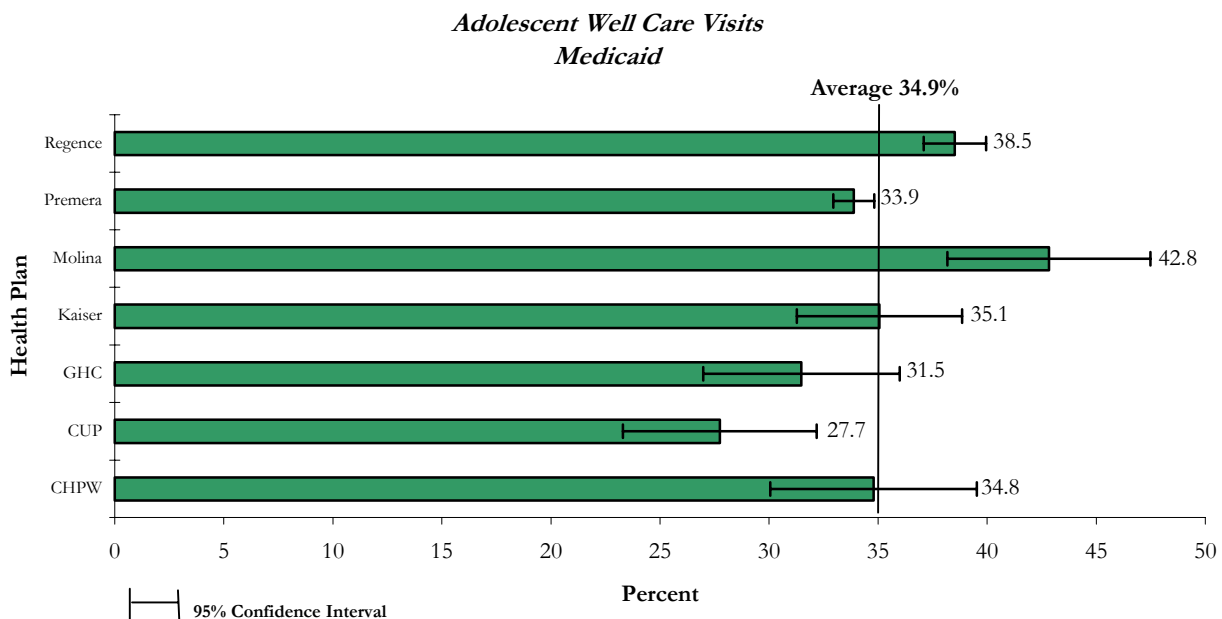
Some states require well child examination proof prior to entering school. Based on a pilot project, Washington determined the burden of a well child exam requirement for school attendance was likely to outweigh the benefit.

What the rates mean

Eligible children and adolescents with no preventive care visits to a provider may indicate an access to care problem. It might also indicate that members, parents, or guardians do not seek services, even though they are accessible.

Rates may also reflect children and adolescents with primary insurance other

than Medicaid, who receive preventive services through that coverage and are represented in the eligible denominator but not the numerator. Moreover, adolescent mothers and pregnant teens receiving prenatal or postpartum care may be missed in this measure if the teen receives services outside the health plan network and the health plan does not have the record.



Although EPSDT studies have shown that often not all components of a preventive care visit are documented, nevertheless, evidence suggests that most providers follow practice guidelines and view counseling as beneficial, even when they do not document some components in the medical record (e.g., anticipatory guidance).

In a large study conducted by the U.S. Preventive Services Task Force, 63 percent of practitioners reported counseling caused

little to no increase in the length of routine visits, 33 percent reported some increase, and four percent reported a substantial increase. Although the study focused on counseling about physical activity, the finding—integrating practitioner advice with other behavioral interventions demonstrates potential for sustained improvement—seem applicable to any preventive visit.

This HEDIS measure does not measure whether there is a follow up referral for treatment, which is a federal EPSDT reporting requirement. Referrals are normally documented in the medical record. With multiple federal, state, county, and

local entities providing preventive care programs, services, and initiatives, a system to track and coordinate all well child and adolescent care and services, is an increasingly important component of a managed care service delivery system.

In a study of EPSDT, the state of Colorado found a high degree of relationship between client notification and performance rates. The study also found that health education and counseling were completed and recorded in the medical record for more than 98 percent of visits. The thoroughness of the education and counseling cannot be readily measured.

USE OF APPROPRIATE MEDICATION FOR PEOPLE WITH ASTHMA

Why this measure is important

Asthma is a lung disease caused by chronic inflammation of the airways, often triggered by allergens such as tobacco smoke, pet dander, dust mites, cockroaches, mold and air pollutants, perfume, exercise and stress. Asthma attacks can be life-threatening.

Asthma is the sixth most common chronic condition in the U.S. and the most common chronic disease in children. Although prevalence is higher in Washington than the nation, hospitalization rates are lower. The cost of asthma related to lost productivity is high. Proper medical management can avoid asthma attacks and reduce the need for urgent care, hospitalization, missed work and school absenteeism.

While asthma affects all ages and ethnic groups, low-income and minority populations are disproportionately affected, such as Black children, who are four times more likely to die from asthma than White

children. Pediatric asthma hospitalizations are five times higher for children in lower income families than for other children. Women of all races have higher rates of death from asthma than men. Prevalence among children under five in poorer households in Washington is twice as high as in those with income above \$20,000.

Description

This measure calculates the proportion of members with persistent asthma (defined as previous year's service and medication utilization) that are prescribed medications acceptable as primary therapy for long-term control of asthma.

Inhaled corticosteroids are the preferred primary therapy for asthma and the only recommended primary therapy for moderate-to-severe asthma. Long-acting beta-agonists are a preferred adjunct therapy, and are not counted independently in the numerator.

2002 Medication for Asthma Ages 5-9

Medicaid

Plan	N	Rate (%)	UCI	LCI
CHPW	571	48.16	52.35	43.98
CUP	89	68.54	78.75	58.33
GHC	116	66.38	75.41	57.35
Kaiser	4	NA	NA	NA
Molina	469	66.95	71.31	62.59
Premiera	111	59.46	69.04	49.88
Regence	14	NA	NA	NA
State Median	66.38			
State Average	66.4			

NA = Sample size < 30

Analysis

Two health plans did not have sufficient sample size for the five to nine year old age group. Five rates ranged from 48 percent (CHPW) to 68 percent (CUP). The statewide average rate is 66 percent.

Rates for the adolescent age group range from 55 percent (CHPW) to 76 percent (CUP). The statewide average rate for six health plans is 56 percent.

Only five health plans had sufficient sample size for adults. Rates range from 51 percent (CHPW) to 71 percent (PBC) with a statewide average of 62 percent.

2002 Medication for Asthma Ages 10-17

Medicaid

Plan	N	Rate (%)	UCI	LCI
CHPW	662	54.68	58.55	50.82
CUP	111	75.68	84.11	67.24
GHC	167	59.28	67.03	51.53
Kaiser	23	NA	NA	NA
Molina	589	63.5	67.47	59.52
Premiera	160	73.75	80.88	66.62
Regence	44	63.64	78.99	48.29
State Median	63.57			
State Average	55.5			

NA = Sample size < 30

2002 Medication for Asthma Ages 18-56

Medicaid

Plan	N	Rate (%)	UCI	LCI
CHPW	259	51.35	57.63	45.07
CUP	113	59.29	68.79	49.79
GHC	78	66.67	77.77	55.56
Kaiser	1	NA	NA	NA
Molina	300	60.33	66.04	54.63
Premiera	76	71.05	81.91	60.2
Regence	2	NA	NA	NA
State Median	60.33			
State Average	61.7			

NA = Sample size < 30

Combined rate

The combined asthma medication rate is the sum of the three numerators divided by the sum of the three denominators. Rates range from 52 percent (CHPW) to 69 percent (PBC). The statewide average rate for all age groups represented in the combined rate is 63 percent.

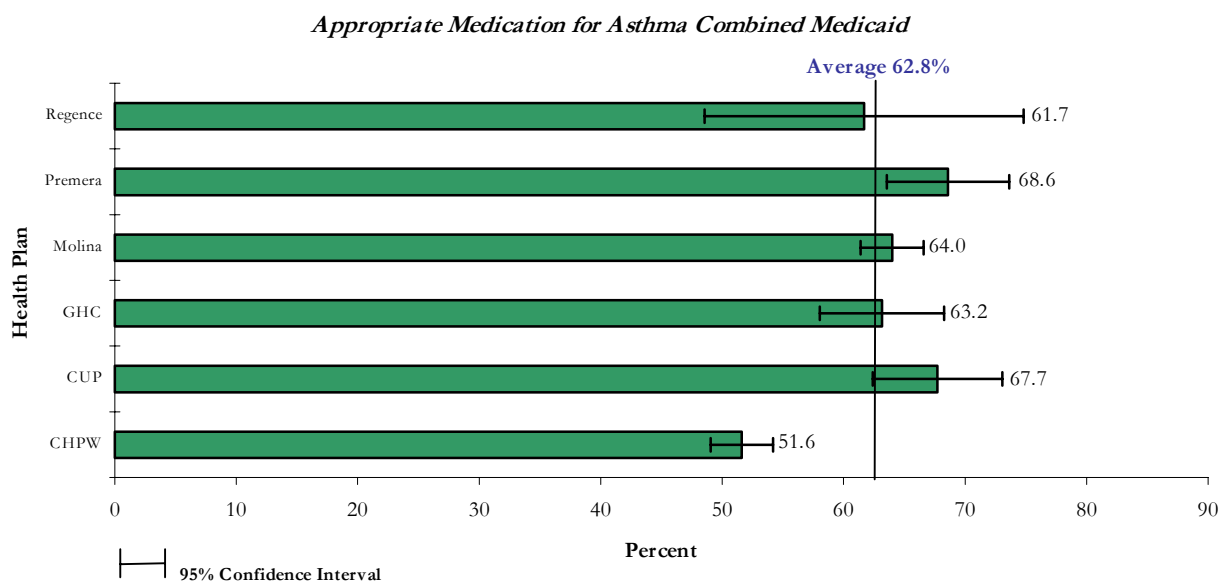
What the rates mean

This is the first year of data. The rates indicate the preferred asthma medications are prescribed in more than half the eligible members across all age groups, with the average highest in the adolescent age group. Stratification by age causes a wider variance in sample sizes and some too small to report.

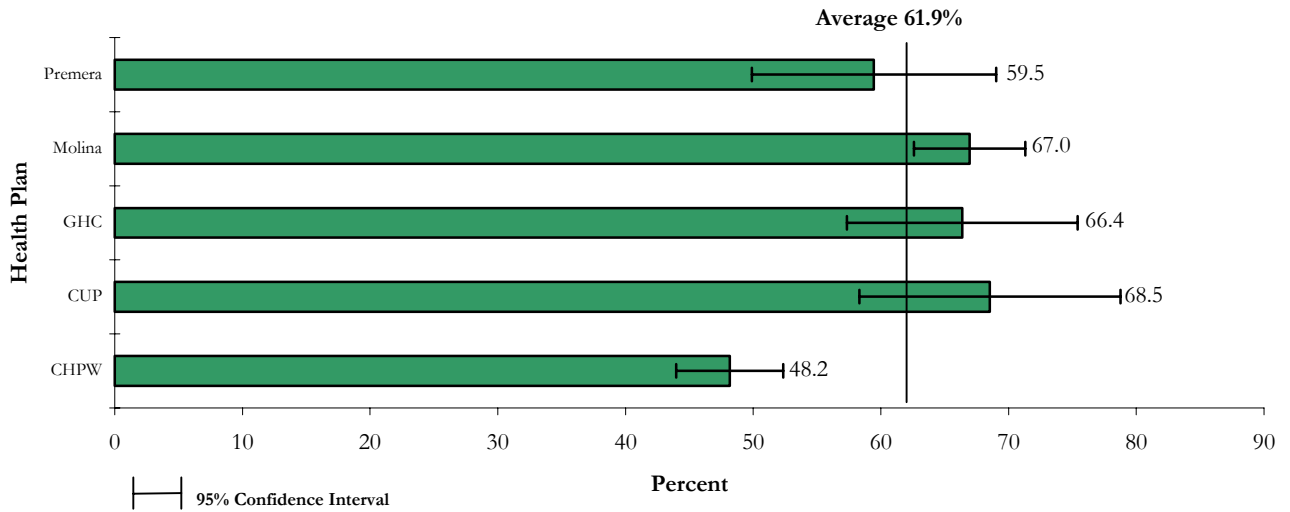
2002 Medication for Asthma Combined

Plan	Medicaid			
	N	Rate (%)	UCI	LCI
CHPW	1492	51.61	54.18	49.04
CUP	313	67.73	73.07	62.39
GHC	361	63.16	68.27	58.04
Kaiser	28	NA	NA	NA
Molina	1358	63.99	66.58	61.4
Premiera	347	68.59	73.62	63.56
Regence	60	61.67	74.8	48.53
State Median	63.58			
State Average	62.8			

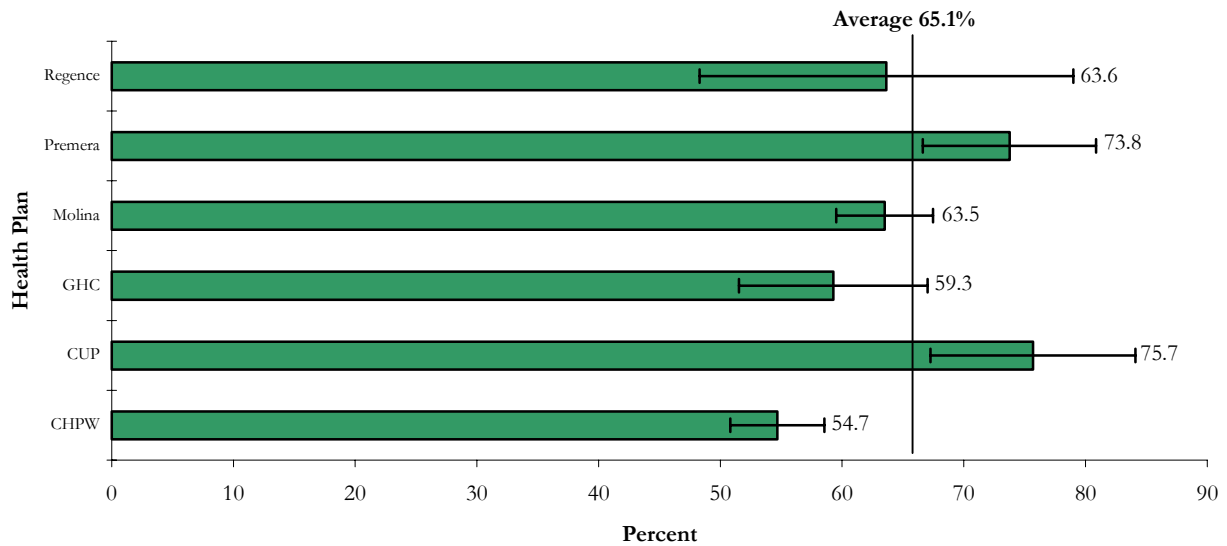
NA = Sample size < 30



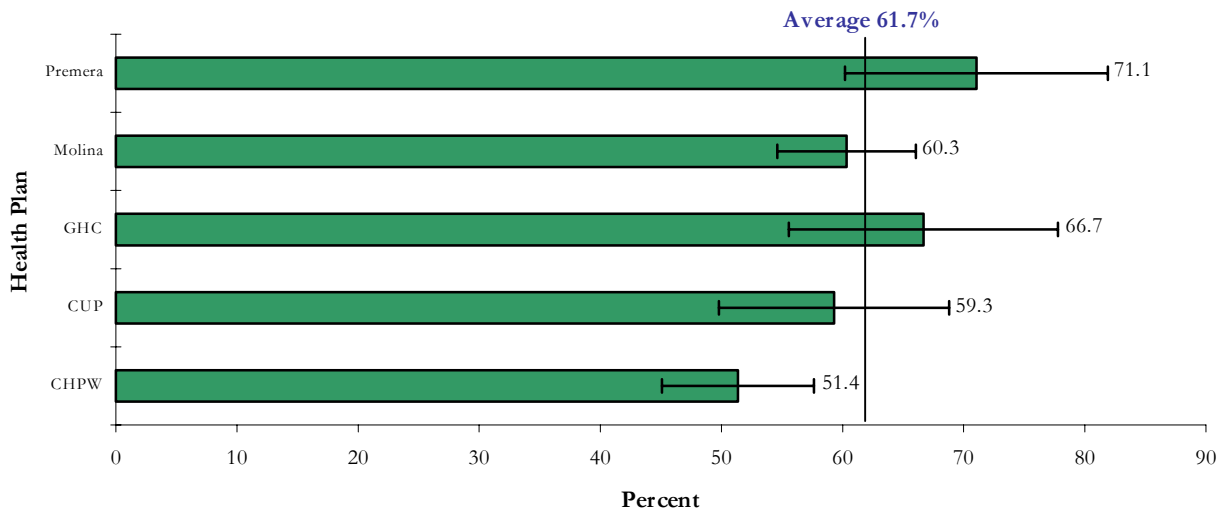
Appropriate Medications for People with Asthma (Ages 5-9) Medicaid



Appropriate Medication for Asthma Age 10-17 Medicaid



Appropriate Medication for Asthma Age 18-56 Medicaid



III. INTERVENTION STRATEGIES

How can rates be improved?

General

Closing the quality gap in health care means seeking new ideas and using available resources to implement better systems of health care delivery. Recommendations included in this report for improving HEDIS rates are based on a synthesis of current literature and initiatives some health plans have found successful. These approaches provide a guide for new improvement activities and community collaboration that can lead to a better health care delivery system in Washington and new vistas of achievement.

Multiple approaches can achieve faster improvement.

The effectiveness of some strategies is well documented and they apply across all HEDIS measures. These strategies include:

- Expand office hours to accommodate parents who are employed.
- Make system changes to allow walk in services (no appointment required).
- Provide or arrange for transportation assistance.
- Establish tracking systems to send postcard and phone call reminders of appointments.
- Consider alternative forms of "office visits," such as e-mail, phone calls, and group visits. There is evidence that these newer alternatives enhance health care services and make good business sense.
- Provide PCPs with health information to give to members directly. This has been shown to be the most effective method of communicating health information.
- Maximize limited resources by coordinating quality improvement interventions and sharing information across stakeholder groups to reduce duplicative efforts. Enhance organization capabilities with federal, state, county and local government and private sector programs that provide similar services. Support the Washington Medicaid Integration Project (WMIP), which seeks to improve continuity and coordination of care and health outcomes through integration of services across state agencies.

Top performing organizations report that building a culture that embraces quality improvement is the single most important factor in delivering high quality health care.

- Collect and analyze demographic data (e.g., race, ethnicity and primary language) with health services data. Use the data to identify health disparities, develop local outreach, education and treatment programs, and improve health parity across demographic groups. Information on Washington counties is available at www.ofm.wa.gov/databook/county/clickmap.htm
- Evaluate quality improvement programs for the health outcomes in target populations, and devote resources to the area likely to be most beneficial.

One study found that less than half the population could understand directions about taking medicine, information about their next appointment, or the meaning of a standard consent form. Yet researchers consistently have found written materials are far above the reading level of most people.

Childhood Immunization

Strategies specific to improve childhood immunizations include:

- Reduce missed opportunities (visits in which a child could have received an immunization but did not, often

because the child's immunization status was not reviewed). This is the easiest way to improve rates. The average child visits a health care provider ten times by their second birthday; the recommended vaccines can be administered in five visits.

- Develop systems that give notices about immunization status to parents during office visits that are not scheduled well child visits.
- Use checklists in the medical record to remind providers while children are in their office that immunizations are due.
- Encourage providers to discuss the importance of immunization during prenatal care visits.
- Subscribe to CHILDPProfile. Immunizations are available from multiple sources outside health plans. Instead of improving access to care, though, population mobility tends to contribute to discontinuity of care and missing, incomplete or inaccurate medical records. When providers do not have ready access to previous records, they may defer needed vaccinations or give unnecessary doses. A comprehensive, confidential, population-based tracking and health promotion immunization registry electronically consolidates vaccination records of multiple healthcare providers, provides complete and accurate information on vaccination status, including due

or late vaccinations, and generates reminder and recall notices.

The goal of CHILDPProfile, which is managed by the Department of Health (DOH), is to achieve 95 percent health care provider participation in the registry by 2006. The Healthy People 2010 goal is 95 percent participation in fully operational population based immunization registries from birth to age six.

- Use available resources to promote accurate, educationally and culturally sensitive public education, correct misinformation, and regain public trust in vaccine safety. Childhood immunizations are historically lower in certain demographic populations, immigrant groups, and in children living in poverty and rural areas. Ensure providers know the facts about immunizations so they are able to explain them to parents who can't read or understand them.
- Post colorful posters with the childhood vaccination schedule and leave brochures in examination and waiting rooms to remind parents about vaccinations during visits that are not well child visits. These are available at no charge from CDC and DOH.
- Give an immunization schedule and record keeper to parents. Encourage them to keep it in a safe place and bring it to every office visit.

- Use the information available for translating Vaccine Information Statements (VIS) in 28 languages at www.imuniz.org/vis. A VIS is required by law to be given with each dose of DTaP, MMR, Varicella, Polio, HiB or Hep B vaccination, but the statement needs translation for non-English parents.
- Subscribe to publications such as Every Child by Two (ECBT), an organization to protect all children from VPD that publishes a bimonthly newsletter *On the Hill*, available on the web at <http://www.ecbt.org/allnews.html>.
- Utilize resources available from programs such as Childhood Immunization Support Program (CISP), sponsored by AAP to improve immunizations for children. The CISP website is <http://www.cispimmunize.org/>
- Keep informed about vaccine safety through the Bill and Melinda Gates Children's Vaccine Program, which gives parents, health care providers, journalists, researchers, and policy makers honest disclosure of science-based research. The website is www.vaccinealliance.org

A report published in 1999 by the National Vaccine Advisory Committee (NVAC) emphasizing the advantages of immunization registries with recommendation on how to increase participation can be accessed on the CDC website.

- Give providers copies of specific information about immunizations available from the Public Health—Seattle and King County. The website is www.metrokc.gov/health/immunization/childimmunity

Prenatal and Postpartum Care

- Incorporate *Healthy People 2010* objectives into health plan and state strategic performance goals and collaborative initiatives to speed achievement of goals. *Healthy People 2010* objectives include:
 - Reduce infant and maternal death, birth complications, low birth weight and preterm births;
 - Increase the proportion of very low birth weight infants born at specialty centers;
 - Increase abstinence from alcohol, cigarette and illicit drugs among pregnant women; and
 - Attain parity in infant mortality across demographic groups.
- Implement model initiatives such as those in a California prenatal care program that substantially improved access, particularly for women at high risk. The study, "Promoting Access to Prenatal Care: Lessons from the California Experience," is available at www.kff.org/2003/20030617a

Well Child and Adolescent Care visits

- Inform women during pregnancy about the availability and importance of well child care preventive services.
- Promote comprehensive health screening before entering school (required in 23 states).
- Support national, state and local businesses that are sharing their marketing channels and expertise to reach customers whose children are likely eligible for Medicaid and the national toll-free hotline number (1-887-KIDS-NOW) used on milk cartons, grocery bags, children's prescriptions and monthly billing statements.

A before/after trial at five urban community health clinics with eight pediatricians showed widespread incomplete and inaccurate documentation of pediatric ambulatory care visits. After introduction of standard forms, documentation significantly increased for all components of the well child exam and overall completeness increased from 35 to 78 percent.

Children move back and forth from Medicaid eligibility as family incomes change. A reporting method that accounts for children moving between public coverage and private insurance and a mechanism to accommodate interrupted eligibility would improve continuity of care.

Studies suggest low- income families perceive prevention as a luxury. Texas uses negative incentives—TANF benefits are reduced for failing to keep EPSDT appointments. Better ways to express the value of preventive care to low income families are needed.

Asthma

- Promote asthma friendly policies and procedures in schools. Discuss use of asthma medications in the school setting and strategies to reduce the need for acute care with local boards of education. A guide published by the CDC for schools is available at www.CDC.gov/healthyyouth/healthtopics/asthma
- Implement disease management principles and functions, e.g., using an asthma client registry, ensuring every member with asthma has an asthma action plan, and giving parents a phone number when asthma symptoms exacerbate.
- Join the Washington Asthma Initiative, a statewide coalition that mobilizes individuals, communities and organizations to improve prevention, diagnosis, and management of asthma. Information is available at www.alaw.org
- Provide information on the danger of second hand smoke, and give parents who smoke information on the DOH Tobacco Quit hotline (www.Quitline.com).

A focus group found that children are concerned whether asthma makes them seem different to their peers (how visible it is) while parents focus on how to avoid the attacks.

IV. CONSIDERATIONS

HEDIS data should be interpreted with consideration of influences on the data, such as sampling, population, and statistical significance.

Sampling. When evaluating HEDIS results, it is important to know that for most measures, only a portion of the Medicaid population is represented. Most measures

require continuous enrollment for 12 months in the same health plan to be included in the denominator. This requirement often excludes many individuals due to short eligibility periods and enrollment discontinuities—common in the Medicaid population. Retroactive Medicaid eligibility presents similar challenges.

Population. Although Medicaid benefits are standard across all health plans in Washington, demographics among health plans differ. By definition, persons enrolled in Medicaid are more economically disadvantaged than those in the commercial population. Researchers have established a clear association between income and health status. HEDIS measures do not take into account demographic differences, and rates are not case-mix adjusted (a method used to make adjustments for differences in social risk, comorbidities, severity of disease, etc.) Separate Medicaid and commercial populations adjust for some of these differences.

Significance. HEDIS measures are designed to show significant differences. Nonetheless, a statistically significant rate difference may not be meaningful in any one

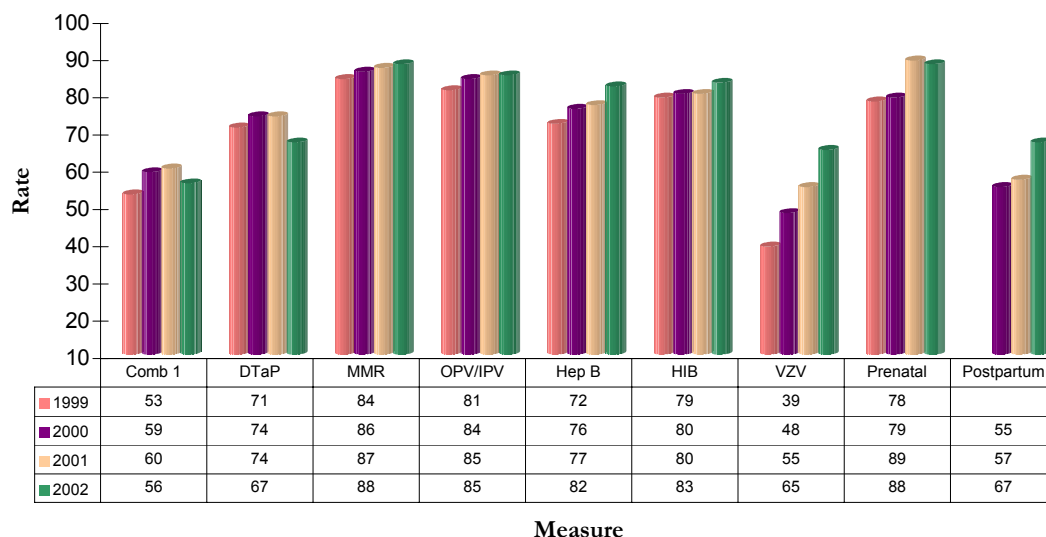
year, but small changes each year can result in meaningful clinical outcomes over time.

Patterns of care delivery (favorable or unfavorable) can also emerge when compared over time and when several measures are considered together. Because health plans have overlapping provider networks, performance rates at the health plan level can mask important variation among individual providers or clinics.

New approaches. Combining all measures in a domain (e.g., children, women, chronic care, etc.) into composite scores similar to Consumer Assessment of Health Plan Surveys (CAHPS) may be useful. Composites could produce more comprehensive quality measurement tools and help focus improvement strategies to accelerate overall gains.

V. STATEWIDE MEDICAID RATES—MULTI MEASURE COMPARISON

*Multi Measure Comparison
Statewide Medicaid Median Rates*



VI. SUMMARY

All Washington health plans improved on at least two measures in 2002 and the statewide median rate increased on six measures. All health plans improved every childhood immunization measure except DTaP (which is likely due to vaccine shortage), and nearly all health plans are getting better on most measures over time. Over the four-year period from 1999 to 2002, every health plan improved the prenatal care rate and five were statistically significant. There is, nevertheless, opportunity for higher achievement.

A recent Alliance of Community Health Plan report, available at www.achp.org, examined HEDIS health care preventive and chronic condition measures for the impact of improved performance on five key HEDIS measures if care was delivered at a 95 percent performance level. The analysis showed health care outcomes such as lives saved, sick days averted and employer's savings.

In a time of grim economic forecasts, this kind of analysis is particularly important because the data demonstrate what happens when health care performance excels. Such information, conducted on a state level in Washington, could motivate us toward achieving—even amid financial cutbacks—the level of quality and excellence to which we are all capable.

Raising our standards is key to having the vision of Dr. Berwick—commitment to standardized excellence in health care, and systems in which we use our enormous resources to raise the bar on performance.

"It is a new system...a lot of the old tools won't work anymore....[We have] the opportunity to open new vistas of achievement."

VII. HEALTH PLAN PROFILES

Medicaid and Commercial Populations

CHPW *Commercial Three Year HEDIS Performance*

	2000		2001		2002	
	N	Rate	N	Rate	N	Rate
<i>Breast Cancer Screening</i>	2489	62%	4408	63%	5025	66%
<i>Childhood immunization - DTaP</i>	30	50%	40	68%	54	57%
<i>Childhood immunization - IPV</i>	30	63%	40	78%	54	87%
<i>Childhood immunization - MMR</i>	30	70%	40	75%	54	83%
<i>Childhood immunization - HIB</i>	30	67%	40	78%	54	80%
<i>Childhood immunization - Hepatitis B</i>	30	50%	40	55%	54	78%
<i>Childhood immunization - VZV</i>	30	20%	40	38%	54	50%
<i>Childhood immunization - Combo 1</i>	30	37%	40	43%	54	52%
<i>Comprehensive diabetic care (eye exam)</i>	411	42%	411	48%	411	50%
<i>Timeliness of Prenatal Care</i>	257	64%	378	82%	411	91%
<i>Postpartum Care</i>	257	64%	378	58%	411	63%

CHPW *Medicaid Four Year HEDIS Performance*

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Childhood immunization - DTaP</i>	411	70%	411	75%	411	74%	411	64%
<i>Childhood immunization - IPV</i>	411	86%	411	85%	411	86%	411	85%
<i>Childhood immunization - MMR</i>	411	85%	411	86%	411	85%	411	88%
<i>Childhood immunization - HIB</i>	411	81%	411	80%	411	77%	411	81%
<i>Childhood immunization - Hepatitis B</i>	411	84%	411	76%	411	77%	411	83%
<i>Childhood immunization - VZV</i>	411	9%	411	33%	411	50%	411	59%
<i>Childhood immunization - Combo 1</i>	411	51%	411	62%	411	61%	411	56%
<i>Timeliness of Prenatal Care</i> ↑↑	362	59%	411	75%	411	83%	411	88%
<i>Postpartum Care</i>	NA	NA	NA	NA	232	57%	411	56%

NA = Not applicable to the population or sample size < 30

CUP
Commercial Four Year HEDIS Performance

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Breast Cancer Screening</i>	NA	NA	265	71%	318	65%	378	70%
<i>Childhood immunization - DTaP</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Childhood immunization - IPV</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Childhood immunization - MMR</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Childhood immunization - HIB</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Childhood immunization - Hepatitis B</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Childhood immunization - VZV</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Childhood immunization - Combo 1</i>	NA	NA	NA	NA	NA	NA	NA	NA
<i>Comprehensive diabetic care (eye exam)</i>	NA	NA	134	19%	181	46%	206	45%
<i>Timeliness of Prenatal Care</i>	30	60%	NA	NA	NA	NA	NA	NA
<i>Postpartum Care</i>	NA	NA	NA	NA	NA	NA	NA	NA

NA = Not applicable to the population or sample size < 30

CUP
Medicaid Four Year HEDIS Performance

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Childhood immunization - DTaP</i>	411	68%	411	69%	411	74%	411	62%
<i>Childhood immunization - IPV</i>	411	77%	411	79%	411	81%	411	82%
<i>Childhood immunization - MMR</i>	411	81%	411	86%	411	85%	411	82%
<i>Childhood immunization - HIB</i>	411	74%	411	79%	411	78%	411	80%
<i>Childhood immunization - Hepatitis B</i>	411	68%	411	77%	411	77%	411	79%
<i>Childhood immunization - VZV</i>	411	31%	411	53%	411	58%	411	60%
<i>Childhood immunization - Comb 1</i> ↑↑	411	48%	411	59%	411	60%	411	55%
<i>Timeliness of Prenatal Care</i> ↑↑	140	59%	401	75%	411	90%	411	85%
<i>Postpartum Care</i>	NA	NA	401	55%	411	57%	411	54%

NA = Not applicable to the population or sample size < 30

GHC
Commercial Four Year HEDIS Performance

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Breast Cancer Screening</i>	27319	79%	411	78%	31160	78%	310	80%
<i>Childhood immunization - DTaP</i>	2508	91%	411	88%	450	89%	431	84%
<i>Childhood immunization - IPV</i>	2508	94%	411	91%	450	93%	431	92%
<i>Childhood immunization - MMR</i>	2508	93%	411	90%	450	92%	431	91%
<i>Childhood immunization - HIB</i>	2508	93%	411	89%	450	89%	431	89%
<i>Childhood immunization - Hepatitis B</i>	2508	86%	411	87%	450	86%	431	87%
<i>Childhood immunization - VZV</i>	2508	34%	411	41%	450	55%	431	65%
<i>Childhood immunization - Combo 1</i>	2508	80%	411	81%	450	80%	431	74%
<i>Comprehensive diabetic care (eye exam)</i>	NA	NA	411	70%	454	76%	456	74%
<i>Timeliness of Prenatal Care</i>	2398	86%	411	84%	419	88%	359	90%
<i>Postpartum Care</i>	NA	NA	NA	NA	419	71%	359	66%

NA = Not applicable to the population or sample size < 30

GHC
Medicaid Four Year HEDIS Performance

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Childhood immunization - DTaP</i>	411	80%	411	81%	431	78%	432	79%
<i>Childhood immunization - IPV</i>	411	88%	411	87%	431	85%	432	89%
<i>Childhood immunization - MMR</i>	411	86%	411	87%	431	88%	432	89%
<i>Childhood immunization - HIB</i>	411	86%	411	84%	431	80%	432	84%
<i>Childhood immunization - Hepatitis B</i>	411	81%	411	84%	431	81%	432	84%
<i>Childhood immunization - VZV</i>	411	30%	411	43%	431	59%	432	65%
<i>Childhood immunization - Combo 1</i>	411	69%	411	71%	431	71%	432	70%
<i>Timeliness of Prenatal Care</i> ↑↑	348	81%	411	79%	431	84%	432	88%
<i>Postpartum Care</i>	NA	NA	NA	NA	431	52%	432	69%

NA = Not applicable to the population or sample size < 30

Kaiser
Commercial Four Year HEDIS Performance

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Breast Cancer Screening</i>	28109	79%	29267	79%	30607	79%	31641	76%
<i>Childhood immunization - DTaP</i>	411	92%	335	90%	3234	89%	3428	86%
<i>Childhood immunization - IPV</i>	411	94%	335	93%	3234	91%	3428	92%
<i>Childhood immunization - MMR</i>	411	95%	335	94%	3234	94%	3428	92%
<i>Childhood immunization - HIB</i>	411	95%	335	94%	3234	91%	3428	90%
<i>Childhood immunization - Hepatitis B</i>	411	87%	335	88%	3234	89%	3428	90%
<i>Childhood immunization - VZV</i>	411	86%	335	89%	3234	91%	3428	91%
<i>Childhood immunization - Combo 1</i>	411	80%	335	81%	3234	81%	3428	77%
<i>Comprehensive diabetic care (eye exam)</i>	411	75%	411	80%	411	80%	411	73%
<i>Timeliness of Prenatal Care</i>	411	93%	411	92%	288	90%	288	93%
<i>Postpartum Care</i>	NA	NA	411	78%	288	73%	288	83%

NA = Not applicable to the population or sample size < 30

Kaiser
Medicaid Four Year HEDIS Performance

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Childhood immunization - DTaP</i>	188	81%	126	91%	432	83%	87	83%
<i>Childhood immunization - IPV</i>	188	88%	126	91%	86	91%	87	91%
<i>Childhood immunization - MMR</i>	188	93%	126	90%	86	92%	87	90%
<i>Childhood immunization - HIB</i>	188	92%	126	94%	86	90%	87	84%
<i>Childhood immunization - Hepatitis B</i>	188	86%	126	93%	86	91%	87	90%
<i>Childhood immunization - VZV</i>	188	73%	126	85%	86	84%	87	86%
<i>Childhood immunization - Combo 1</i>	188	71%	126	83%	86	78%	87	78%
<i>Timeliness of Prenatal Care</i>	NA	NA	94	87%	58	83%	47	91%
<i>Postpartum Care</i>	NA	NA	94	76%	58	74%	47	66%

NA = Not applicable to the population or sample size < 30

Premera
Commercial Four Year HEDIS Performance

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Breast Cancer Screening</i>	324	80%	306	80%	306	80%	282	82%
<i>Childhood immunization - DTaP</i>	414	84%	415	81%	415	81%	431	71%
<i>Childhood immunization - IPV</i>	414	90%	415	85%	415	85%	431	90%
<i>Childhood immunization - MMR</i>	414	92%	415	90%	415	90%	431	91%
<i>Childhood immunization - HIB</i>	414	85%	415	85%	415	85%	431	87%
<i>Childhood immunization - Hepatitis B</i>	414	77%	415	80%	415	80%	431	83%
<i>Childhood immunization - VZV</i>	414	47%	415	50%	415	50%	431	71%
<i>Childhood immunization - Combo 1</i>	414	66%	415	66%	415	66%	431	59%
<i>Comprehensive diabetic care (eye exam)</i>	401	57%	407	71%	407	71%	425	93%
<i>Timeliness of Prenatal Care</i>	431	89%	422	95%	422	95%	353	96%
<i>Postpartum Care</i>	NA	NA	422	71%	422	71%	353	79%

NA = Not applicable to the population or sample size < 30

Premera
Medicaid Four Year HEDIS Performance

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Childhood immunization - DTaP</i>	432	74%	431	71%	431	71%	432	62%
<i>Childhood immunization - IPV</i>	432	85%	431	82%	431	82%	432	83%
<i>Childhood immunization - MMR</i>	432	88%	431	84%	431	84%	432	88%
<i>Childhood immunization - HIB</i>	432	83%	431	80%	431	80%	432	82%
<i>Childhood immunization - Hepatitis B</i>	432	79%	431	79%	431	79%	432	77%
<i>Childhood immunization - VZV</i>	432	41%	431	48%	431	47%	432	59%
<i>Childhood immunization - Comb 1</i> ↓↓	432	62%	431	58%	431	58%	432	50%
<i>Timeliness of Prenatal Care</i> ↑↑	430	74%	432	89%	432	89%	425	93%
<i>Postpartum Care</i>	NA	NA	432	57%	432	57%	425	60%

NA = Not applicable to the population or sample size < 30

Regence
Commercial Three Year HEDIS Performance

	2000		2001		2002	
	N	Rate	N	Rate	N	Rate
<i>Breast Cancer Screening</i>	2760	77%	2474	76%	431	73%
<i>Childhood immunization - DTaP</i>	430	74%	329	78%	305	62%
<i>Childhood immunization - IPV</i>	430	78%	329	85%	305	84%
<i>Childhood immunization - MMR</i>	430	82%	329	89%	305	87%
<i>Childhood immunization - HIB</i>	430	79%	329	85%	305	84%
<i>Childhood immunization - Hepatitis B</i>	430	64%	329	72%	305	69%
<i>Childhood immunization - VZV</i>	430	56%	329	57%	305	68%
<i>Childhood immunization - Combo 1</i>	430	51%	329	62%	305	48%
<i>Comprehensive diabetic care (eye exam)</i>	418	51%	414	62%	430	56%
<i>Timeliness of Prenatal Care</i>	432	75%	427	87%	426	88%
<i>Postpartum Care</i>	432	72%	427	78%	426	73%

Regence
Medicaid Three Year HEDIS Performance

	2000		2001		2002	
	N	Rate	N	Rate	N	Rate
<i>Childhood immunization - DTaP</i>	429	74%	429	74%	431	68%
<i>Childhood immunization - IPV</i>	429	84%	429	84%	431	81%
<i>Childhood immunization - MMR</i>	429	87%	429	87%	431	87%
<i>Childhood immunization - HIB</i>	429	80%	429	80%	431	83%
<i>Childhood immunization - Hepatitis B</i>	429	69%	429	69%	431	76%
<i>Childhood immunization - VZV</i>	429	48%	429	48%	431	68%
<i>Childhood immunization - Combo 1</i>	429	53%	429	52%	431	58%
<i>Timeliness of Prenatal Care</i> ↑↑	429	71%	90	90%	432	86%
<i>Postpartum Care</i>	429	62%	90	77%	432	69%

Medicaid Only Population

Molina Medicaid Three Year HEDIS Performance

	2000		2001		2002	
	N	Rate	N	Rate	N	Rate
<i>Childhood immunization - DTaP</i>	453	64%	453	79%	453	67%
<i>Childhood immunization - IPV</i>	453	73%	453	87%	453	88%
<i>Childhood immunization - MMR</i>	453	76%	453	87%	453	89%
<i>Childhood immunization - HIB</i>	453	73%	453	84%	453	83%
<i>Childhood immunization - Hepatitis B</i>	453	69%	453	78%	453	81%
<i>Childhood immunization - VZV</i>	453	40%	453	57%	453	69%
<i>Childhood immunization - Combo 1</i>	453	51%	453	65%	453	56%
<i>Timeliness of Prenatal Care</i>	447	86%	451	93%	453	93%
<i>Postpartum Care</i>	447	54%	451	60%	453	61%

Commercial Only Population

Aetna *Commercial Four Year HEDIS Performance*

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Breast Cancer Screening</i>	370	82%	268	86%	2613	78%	212	84%
<i>Childhood immunization - DTaP</i>	270	87%	322	77%	429	78%	413	64%
<i>Childhood immunization - IPV</i>	270	86%	322	81%	429	81%	413	84%
<i>Childhood immunization - MMR</i>	270	94%	322	88%	429	88%	413	89%
<i>Childhood immunization - HIB</i>	270	91%	322	82%	429	82%	413	84%
<i>Childhood immunization - Hepatitis B</i>	270	82%	322	71%	429	74%	413	76%
<i>Childhood immunization - VZV</i>	270	71%	322	71%	429	68%	413	76%
<i>Childhood immunization - Combo 1</i>	270	72%	322	59%	429	65%	413	52%
<i>Comprehensive diabetic care (eye exam)</i>	NA	NA	442	60%	415	60%	454	62%
<i>Timeliness of Prenatal Care</i>	144	91%	296	84%	351	94%	321	92%
<i>Postpartum Care</i>	NA	NA	296	71%	351	76%	321	71%

NA = Not applicable to the population or sample size < 30

PacifiCare *Commercial Three Year HEDIS Performance*

	1999		2000		2001		2002	
	N	Rate	N	Rate	N	Rate	N	Rate
<i>Breast Cancer Screening</i>	361	74%	343	76%	343	76%	321	79%
<i>Childhood immunization - DTaP</i>	425	73%	382	82%	421	84%	430	82%
<i>Childhood immunization - IPV</i>	425	81%	382	87%	421	89%	430	87%
<i>Childhood immunization - MMR</i>	425	83%	382	87%	421	92%	430	87%
<i>Childhood immunization - HIB</i>	425	79%	382	84%	421	88%	430	84%
<i>Childhood immunization - Hepatitis B</i>	425	72%	382	80%	421	78%	430	80%
<i>Childhood immunization - VZV</i>	425	45%	382	56%	421	71%	430	56%
<i>Childhood immunization - Combo 1</i>	425	59%	382	67%	421	68%	430	67%
<i>Comprehensive diabetic care (eye exam)</i>	NA	NA	442	41%	439	58%	453	41%
<i>Timeliness of Prenatal Care</i>	169	88%	447	84%	447	88%	352	84%
<i>Postpartum Care</i>	NA	NA	447	72%	447	72%	352	72%

NA = Not applicable to the population or sample size < 30

THE COMMERCIAL POPULATION

Required measures

For the past three years, NCQA reports substantial quality improvements in commercial health plans. Some organizations are performing at or above benchmarks established in *Healthy People 2010*. Because the populations differ, the measures required for the commercial population are not the same as those for Medicaid. Required measures included in this report for the Commercial population this year include:

- Childhood Immunization
- Adolescent Immunization
- Breast Cancer Screening
- Cervical Cancer Screening
- Beta-Blocker treatment after a heart attack
- Comprehensive Diabetic care (eye examination only)
- Follow up after hospitalization for mental illness (30 day only)
- Cholesterol management after acute cardiovascular events (screening rates) and
- Antidepressant medication management

CHILDHOOD IMMUNIZATIONS

Description

The HEDIS Childhood Immunization measure is a composite that calculates the proportion of children continuously enrolled in the health plan for twelve months prior to their second birthday and who receive the following immunizations by the time period specified and by the child's second birthday:

*4 DTaP (diphtheria-tetanus toxoid-acellular pertussis)

*3 IPV (injectable poliomyelitis)

*1 MMR (measles-mumps-rubella)

*3 HiB (Haemophilus influenza type B meningitis)

*3 Hep B (Hepatitis B)

*1 VZV (Varicella or Chicken pox)

HEDIS also calculates two combination rates. The Combination 1 (Comb 1) rate, which includes all the above immunizations except VZV, is included in this report.

2002 Childhood Immunization - DTaP

Plan	Commercial			
	N	Rate (%)	UCI	LCI
<i>Aetna</i>	413	64.41	59.67	69.15
<i>CHPW</i>	411	63.99	68.75	59.23
<i>CUP</i>	411	62.29	67.09	57.48
<i>GHC</i>	432	78.7	82.68	74.73
<i>Kaiser</i>	87	82.76	91.27	74.25
<i>Pacificare</i>	34.3	71.13	75.55	66.71
<i>Premiera</i>	432	61.57	66.28	56.87
<i>Regence</i>	431	68.21	72.73	63.7
<i>State Median</i>	66.67			
<i>State Average</i>	69			

2002 Childhood Immunization - IPV

Commercial

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	413	84.26	87.89	80.63
<i>CHPW</i>	54	87.04	96.92	77.15
<i>CUP</i>	7	NA	NA	NA
<i>GHC</i>	431	92.34	94.97	89.72
<i>Kaiser</i>	3438	91.51	92.45	90.56
<i>Pacificare</i>	430	88.97	92.06	85.87
<i>Premiera</i>	430	90.38	93.29	87.46
<i>Regence</i>	305	83.93	88.22	79.65
<i>State Median</i>	88.42			
<i>State Average</i>	75.6			

NA = Sample size < 30

2002 Childhood Immunization - MMR

Commercial

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	413	88.86	92.02	85.71
<i>CHPW</i>	54	83.33	94.2	72.47
<i>CUP</i>	7	NA	NA	NA
<i>GHC</i>	431	91.42	94.18	88.65
<i>Kaiser</i>	3438	91.59	92.54	90.65
<i>Pacificare</i>	430	92.72	95.31	90.14
<i>Premiera</i>	431	90.95	93.78	88.13
<i>Regence</i>	305	87.21	91.12	83.3
<i>State Median</i>	89.91			
<i>State Average</i>	88.9			

NA = Sample size < 30

2002 Childhood Immunization - HiB

Commercial

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	413	83.78	87.45	80.1
<i>CHPW</i>	54	79.63	91.3	67.96
<i>CUP</i>	7	NA	NA	NA
<i>GHC</i>	431	88.63	91.74	85.52
<i>Kaiser</i>	3438	90.23	92.23	89.22
<i>Pacificare</i>	430	88.97	92.06	85.87
<i>Premiera</i>	431	87.24	90.51	83.97
<i>Regence</i>	305	83.61	87.93	79.29
<i>State Median</i>	85.51			
<i>State Average</i>	85.6			

NA = Sample size < 30

2002 Childhood Immunization - Hepatitis B

Commercial

<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	413	76.27	80.5	72.05
<i>CHPW</i>	54	77.78	89.79	89.79
<i>CUP</i>	7	NA	NA	NA
<i>GHC</i>	431	87.01	90.3	90.3
<i>Kaiser</i>	3438	90.17	91.18	91.18
<i>Pacificare</i>	430	82.63	86.34	78.91
<i>Premiera</i>	431	83.06	86.72	86.72
<i>Regence</i>	305	68.85	74.21	74.21
<i>State Median</i>	80.42			
<i>State Average</i>	80.5			

NA = Sample size < 30

2002 Childhood Immunization - VZV

<i>Commercial</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	413	76.27	80.5	72.05
<i>CHPW</i>	54	50	64.26	35.74
<i>CUP</i>	7	NA	NA	NA
<i>GHC</i>	431	65.43	70.04	60.82
<i>Kaiser</i>	3438	90.98	91.96	90.01
<i>Pacificare</i>	430	61.74	66.47	57
<i>Premiera</i>	431	70.53	74.95	66.11
<i>Regence</i>	305	67.87	73.27	62.46
<i>State Median</i>	69.2			
<i>State Average</i>	70.2			

NA = Sample size < 30

2002 Childhood Immunization - Comb 1

<i>Commercial</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	413	51.57	56.51	46.63
<i>CHPW</i>	54	51.85	66.1	37.6
<i>CUP</i>	7	NA	NA	NA
<i>GHC</i>	431	74.48	78.71	70.25
<i>Kaiser</i>	3438	76.76	78.19	75.33
<i>Pacificare</i>	453	63.24	67.87	58.61
<i>Premiera</i>	431	58.7	63.47	53.94
<i>Regence</i>	305	47.54	53.31	41.77
<i>State Median</i>	55.28			
<i>State Average</i>	60.2			
<i>Healthy People 2010</i>	90			

NA = Sample size < 30

ADOLESCENT IMMUNIZATIONS

Description

This measure is the percentage of enrolled adolescents who turned 13 years old during the measurement year, and were continuously enrolled for 12 months immediately prior to their 13th birthday, and had a second dose of MMR, three Hepatitis B and one VZV by their 13th birthday. The measure also calculated two combination measures.

2002 Adolescent Immunization - MMR

<i>Commercial</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	424	72.41	76.78	68.03
<i>GHC</i>	432	83.8	87.39	80.21
<i>Kaiser</i>	411	87.1	90.47	83.74
<i>Pacificare</i>	432	80.19	84.07	76.30
<i>Premiera</i>	428	83.18	86.84	79.52
<i>Regence</i>	432	73.15	77.44	68.85
<i>State Median</i>	83.18			
<i>State Average</i>	79.9			

CERVICAL CANCER SCREENING

The *Healthy People 2010* goal is 90 percent for women 18 years and older that have had a Pap test within three years.

A second goal is to decrease the death rate from cancer of the cervix to two per 100,000 population, or a 97 percent rate of Pap tests.

Description

This measure is the percentage of women who are age 18 through 64 and had at least one Pap test during the past three years with continuous enrollment in the same health plan during that period.

2002 Cervical cancer screening

Plan	Commercial			
	N	Rate (%)	UCI	LCI
Aetna	194	87.11	92.09	82.14
CHPW	411	76.64	80.85	72.43
CUP	288	73.26	78.55	67.98
GHC	278	88.13	92.11	84.15
Kaiser	411	85.64	89.16	82.13
Pacificare	275	81.37	86.26	76.47
Premiera	246	89.43	93.48	85.39
Regence	427	81.97	85.73	78.2
State Median	85.64			
State Average	83.2			
Healthy People 2010	90			

BREAST CANCER SCREENING

The *Healthy People 2010* goal for breast cancer screening is 70 percent. Another goal is to reduce the death rate from breast cancer to 22 per 100,000 females or by 20 percent.

Description

The Breast Cancer Screening measure is the percentage of women age 50 through 69 who were continuously enrolled during the measurement year and who had at least one mammogram during the measurement year or the prior year.

2002 Breast cancer screening

Plan	Commercial			
	N	Rate (%)	UCI	LCI
Aetna	212	84.43	89.55	79.32
CHPW	5025	65.89	67.21	64.57
CUP	378	69.84	74.6	65.08
GHC	310	79.68	84.32	75.04
Kaiser	31641	76.43	76.9	75.96
Pacificare	321	79.43	84.05	74.82
Premiera	282	81.91	86.58	77.25
Regence	431	73.32	77.61	69.03
State Median	76.43			
State Average	75.9			

BETA-BLOCKER TREATMENT AFTER A HEART ATTACK

2002 Beta-blocker after heart attack

Description

This measure assesses the percentage of enrolled members 35 years and older who were hospitalized and discharged alive from January 1 to December 24 of the measurement year with a diagnosis of acute myocardial infarction and who received a prescription for beta-blockers upon discharge. The intent of this measure is to assess whether appropriate follow-up care has been rendered to members who suffer a heart attack.

Commercial

Plan	N	Rate (%)	UCI	LCI
Aetna	23	NA	NA	NA
GHC	222	93.69	97.12	90.27
Kaiser	289	98.62	100	97.1
Pacificare	38	97.14	100	90.19
Premiera	88	97.73	100	94.05
Regence	19	NA	NA	NA
State Median	97.73			
State Average	96.8			

NA = Sample size < 30

EYE EXAMS FOR DIABETES

2002 Diabetic care - Eye Exam

Commercial

Plan	N	Rate (%)	UCI	LCI
Aetna	454	62.11	66.69	57.54
CHPW	411	50.36	55.32	45.41
CUP	206	45.15	52.18	38.11
GHC	456	74.12	78.25	69.99
Kaiser	411	73.24	77.64	68.83
Pacificare	430	63.24	67.87	58.61
Premiera	425	92.94	95.49	90.39
Regence	430	56.05	60.85	51.24
State Median	62.68			
State Average	64.9			

Description

This measure is one component of the comprehensive diabetes composite measure. It assesses the percentage of members aged 18 to 75 years with type 1 and type 2 diabetes who were continuously enrolled during the measurement year, and who had a retinal eye exam performed during the year.

FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

2002 Follow-up for mental illness

Description

This measure is the percentage of discharges for members 6 years and older who were hospitalized for treatment of selected mental health disorders, who were continuously enrolled for 30 days after discharge, and who were seen on an ambulatory basis or were in day/night treatment with a mental health provider.

Commercial

Plan	N	Rate (%)	UCI	LCI
<i>Aetna</i>	76	82.89	92.02	73.77
<i>GHC</i>	451	79.82	83.64	76.01
<i>Kaiser</i>	767	75.75	78.85	72.65
<i>Pacificare</i>	58	74.14	86.27	62.01
<i>Premiera</i>	174	59.77	67.34	52.2
<i>Regence</i>	50	64	78.3	49.7
<i>State Median</i>	77.79			
<i>State Average</i>	72.4			

CHOLESTEROL MANAGEMENT AFTER ACUTE CARDIOVASCULAR EVENTS

Description

The percentage of members 18 to 75 years of age on December 31st of the measurement year, who were discharged alive in the year prior to the measurement year for acute myocardial infarction, coronary artery bypass graft, or percutaneous transluminal coronary angioplasty, and had evidence of LDL-C screening and an LDL-C of less than 130 mg/dL.

2002 Cholesterol – LDL-C screening

<i>Commercial</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	53	88.68	98.15	79.21
<i>GHC</i>	394	80.71	84.73	76.69
<i>Kaiser</i>	599	78.8	82.15	75.44
<i>Pacificare</i>		88.58		
<i>Premiera</i>	183	85.79	91.12	80.46
<i>Regence</i>	61	65.57	78.32	52.83
<i>State Median</i>	80.71			
<i>State Average</i>	79.9			

2002 Cholesterol - LDL-C <130mg/dl

<i>Commercial</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	53	67.92	81.43	54.41
<i>GHC</i>	394	66.75	71.53	61.97
<i>Kaiser</i>	599	72.45	76.12	68.79
<i>Pacificare</i>		50.46		
<i>Premiera</i>	183	69.4	76.35	62.45
<i>Regence</i>	61	32.79	45.39	20.19
<i>State Median</i>	67.92			
<i>State Average</i>	61.9			

ANTIDEPRESSANT MEDICATION MANAGEMENT

2002 Antidepressant Medication Practitioner Contacts

Description

This measure assesses three components of successful pharmacological management of depression: optimal practitioner contacts for medication management, effective acute phase treatment, and effective continuation phase treatment. The specifications are lengthy and can be found in detail in the HEDIS Technical Specifications manual and on the NCQA website.

<i>Commercial</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	411	16.55	20.26	12.83
<i>CHPW</i>	450	8	10.62	5.38
<i>CUP</i>	50	12	22.01	1.99
<i>GHC</i>	4985	16.47	17.51	15.43
<i>Kaiser</i>	4886	11.09	11.98	10.2
<i>Pacificare</i>	395	15.19	18.86	11.52
<i>Premiera</i>	813	15.25	17.79	12.72
<i>Regence</i>	129	10.08	15.66	4.5
<i>State Median</i>	13.63			
<i>State Average</i>	12.8			

***2002 Antidepressant Medication
Acute Phase***

<i>Commercial</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	411	60.1	64.95	55.24
<i>CHPW</i>	450	35.56	40.09	31.02
<i>CUP</i>	50	48	62.85	33.15
<i>GHC</i>	4985	70.49	71.77	69.22
<i>Kaiser</i>	4886	68.07	69.39	66.75
<i>Pacificare</i>	395	61.01	65.95	56.08
<i>Premiera</i>	813	63.96	67.32	60.6
<i>Regence</i>	129	67.44	75.92	58.97
<i>State Median</i>	62.03			
<i>State Average</i>	59.1			

***2002 Antidepressant Medication
Continuation Phase***

<i>Commercial</i>				
<i>Plan</i>	<i>N</i>	<i>Rate (%)</i>	<i>UCI</i>	<i>LCI</i>
<i>Aetna</i>	411	43.8	48.71	38.88
<i>CHPW</i>	450	21.78	25.7	17.85
<i>CUP</i>	50	38	52.45	23.55
<i>GHC</i>	4985	53.06	54.45	51.66
<i>Kaiser</i>	4886	52.15	53.56	50.74
<i>Pacificare</i>	395	48.61	53.66	43.55
<i>Premiera</i>	813	46.37	49.86	42.88
<i>Regence</i>	129	47.29	46.29	38.28
<i>State Median</i>	45.09			
<i>State Average</i>	43.2			

APPENDIX A

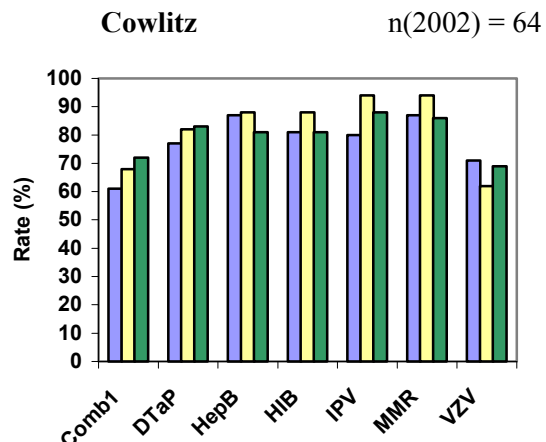
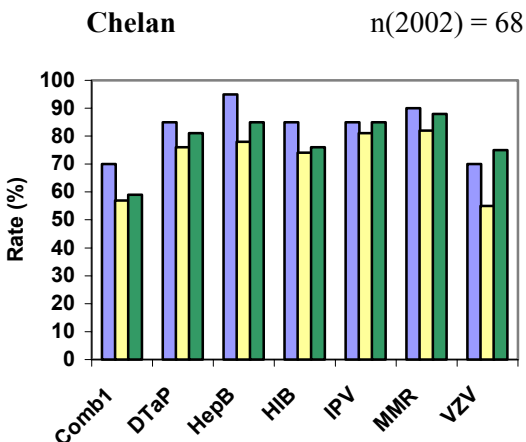
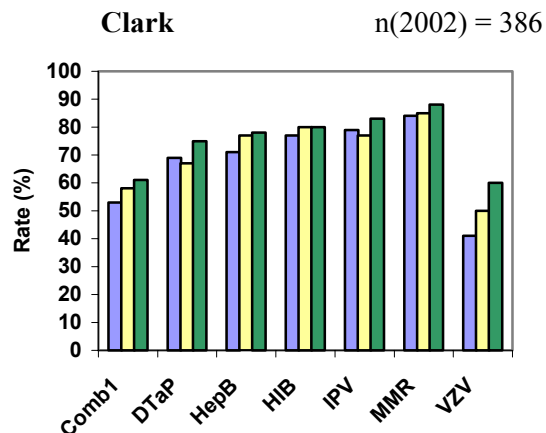
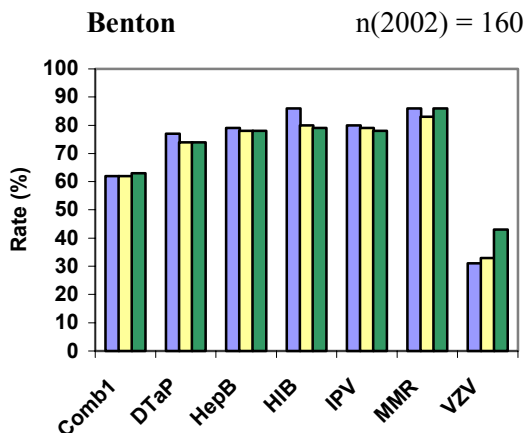
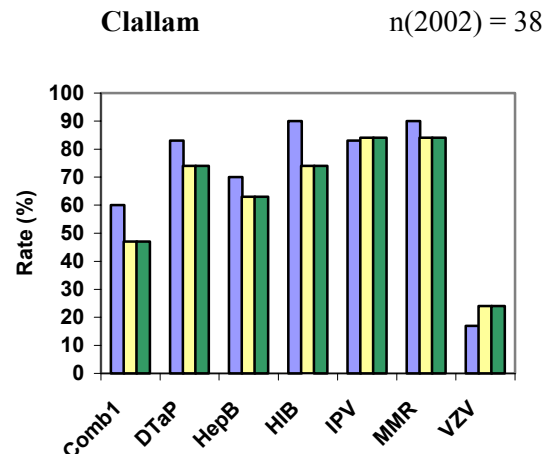
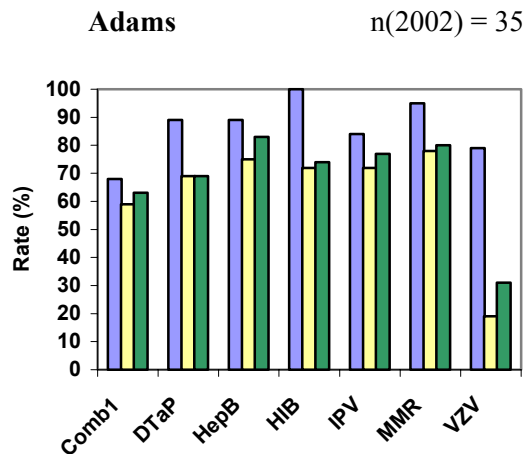
2002 MANAGED CARE			
Health Plan Name	Abbreviation	Population	Service Counties
Aetna US Healthcare	Aetna	Commercial	Adams, Chelan, Douglan, Grant, Island, King, Kitsap, Okanogan, Lewis, Pierce, Snohomish, Thurston
Community Health Plan of Washington	CHPW	Medicaid, commercial	Adams, Benton, Chelan, Clark, Cowlitz, Douglan, Ferry, Franklin, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pend Orielle, Pierce, Skamania, Snohomish, Spokane, Skagit, Stevens, Thurston, Walla Walla, Whatcom, Yakima,
Columbia United Providers	CUP	Medicaid, commercial	Clark, Cowlitz, Klickitat, Skamania, Wahkiakum
Group Health Cooperative	GHC	Medicaid, commercial	Benton, Columbia, Franklin, Grays Harbor, King, Kitsap, Kititas, Lewis, Lincoln, Mason, Pend Orielle, Pierce, San Yuan, Skagit, Stevens, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, Yakima
Kaiser Foundation Health Plan of the Northwest	Kaiser	BH Plus, commercial	Clark, Cowlitz , Lewis, Skamania, Wahkiakum
Molina Healthcare of Washington Inc.	Molina	Medicaid	Adams, Benton, Chelan, Clallam, Columbia, Cowlitz, Douglas, Garfield, Grant, Island, King, Kitsap, Lewis, Lincoln, Mason, Okanogan, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, Yakima
PacifiCare	PacifiCare	Commercial	Clark, Grays Harbor, King, Lewis, Mason, Pierce, Snohomish, Thurston
Premera Blue Cross	PBC	Medicaid, commercial	Adams, Asotin, Benton, Chelan, C9olumbia, Douglas, Franklin, Ferry, Garfield, Grant, Island, King, Kititas, Lincoln, Okanogan, Pacific, Pend Oreille, Pierce, Spokane, Stevens, Whatcom, Whitman, Yakima
Regence BlueShield and RegenceCare	RBS	Medicaid, commercial	King, Kitsap, Pierce, San Juan, Snohomish, Yakima

Childhood immunization rates vary across counties. Appendix A shows the health plans represented in these counties in 2002. Only counties with 30 or more children represented in the sample are included here. More detailed information and additional analysis is available from MAA by calling 360-725-1618 or e-mail www.geimecd1@dshs.wa.gov

Rate 2000

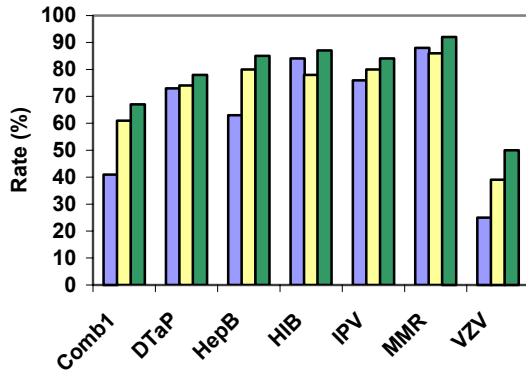
Rate 2001

Rate 2002



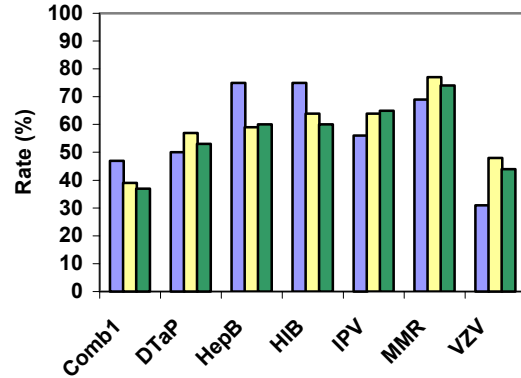
Franklin

n(2002) = 86



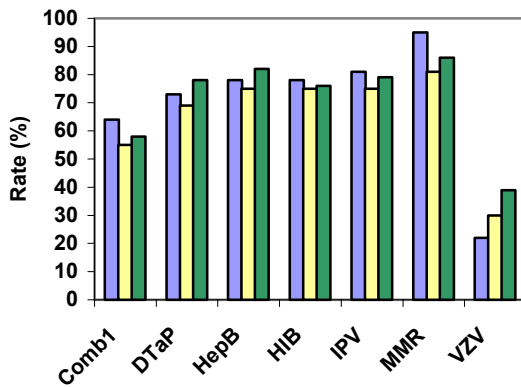
Island

n(2002) = 37



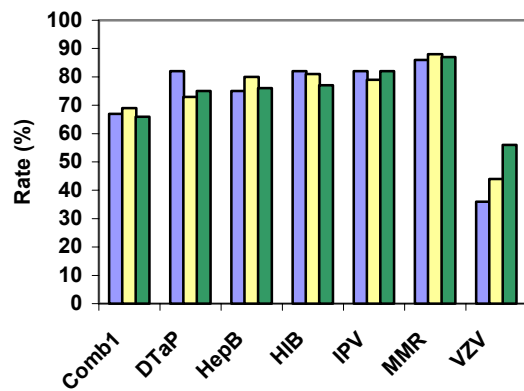
Grant

n(2002) = 76



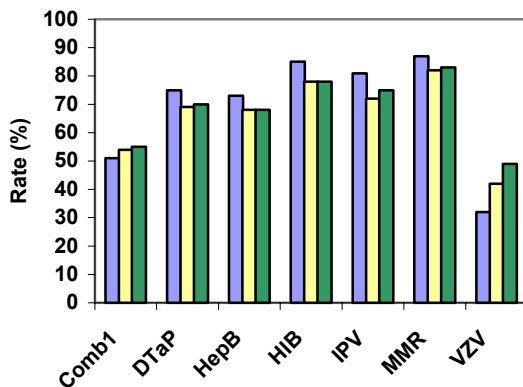
King

n(2002) = 106



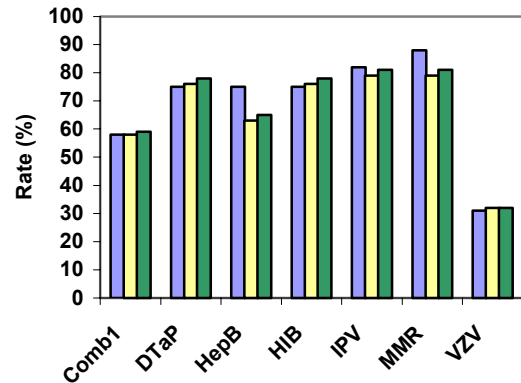
Grays Harbor

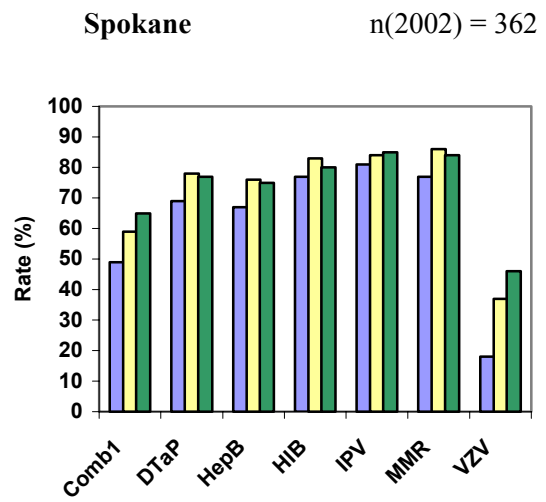
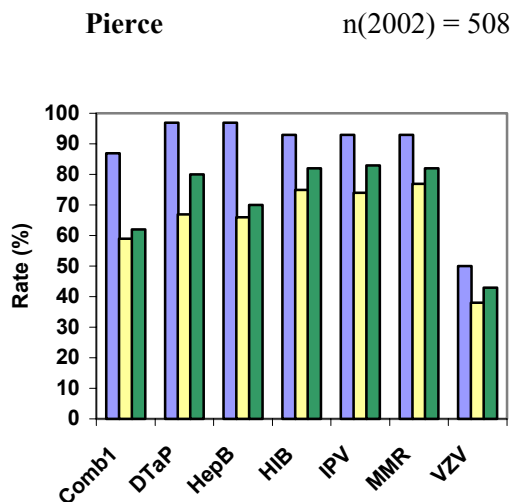
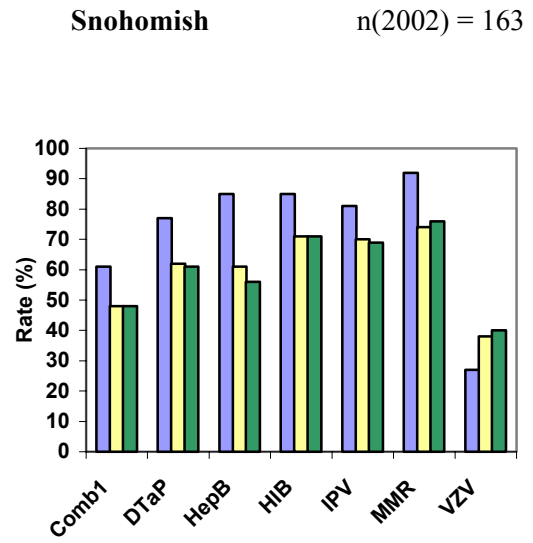
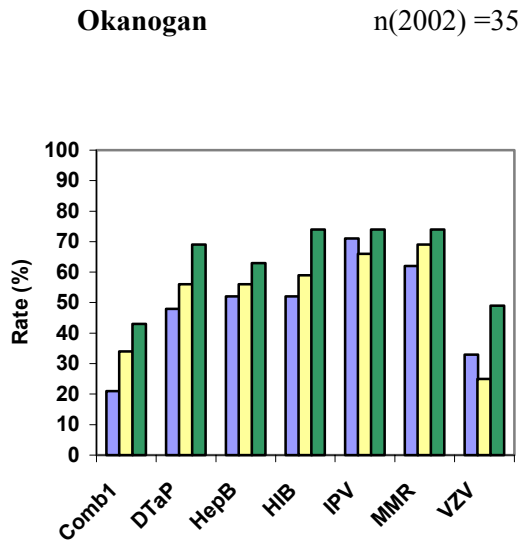
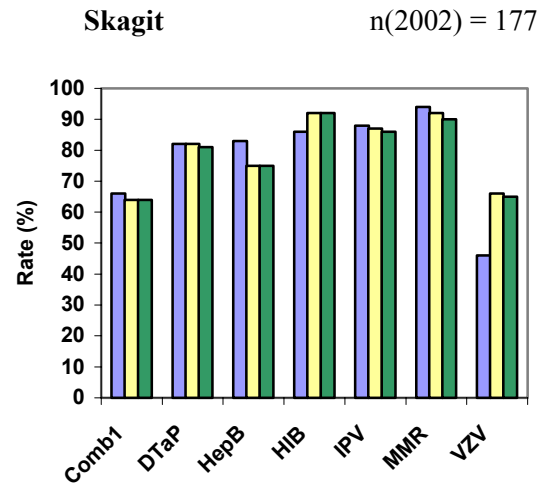
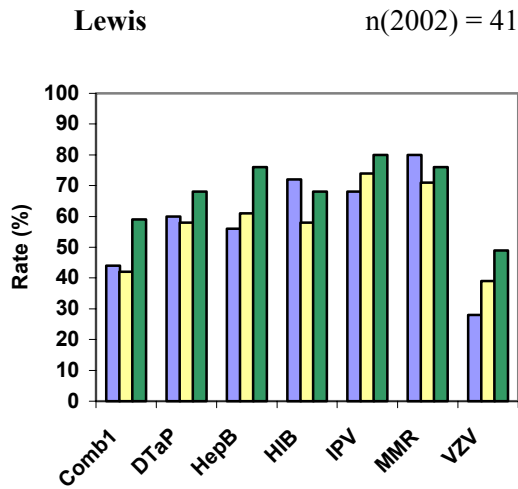
n(2002) = 43



Kitsap

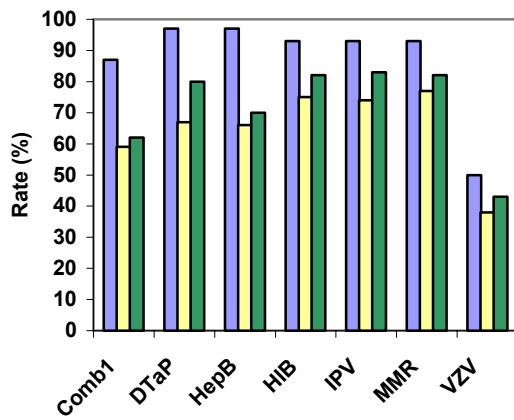
n(2002) = 736





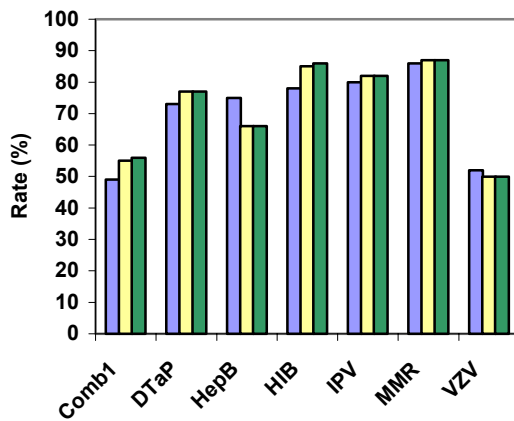
Thurston

n(2002) = 82



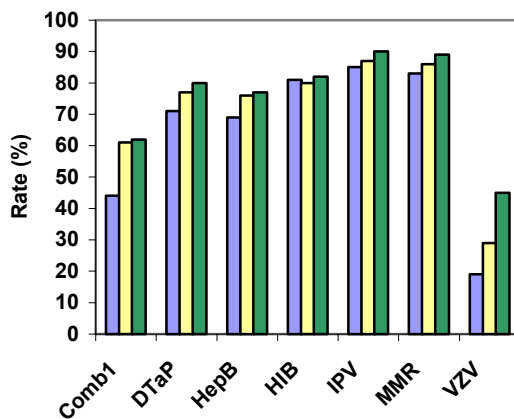
Whatcom

n(2002) = 229



Yakima

n(2002) = 185



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